S. HRG. 103-964

MEDICARE ISSUES UNDER HEALTH CARE REFORM

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

APRIL 12, 1994

Printed for the use of the Committee on Finance

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MEDICARE ISSUES UNDER HEALTH CARE REFORM

TUESDAY, APRIL 12, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Riegle, Rockefeller, Daschle, Conrad, Packwood, Chafee, Durenberger, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–23, April 8, 1994]

FINANCE COMMITTEE SETS HEARING ON MEDICARE ISSUES

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on Medicare issues and health reform.

The hearing will begin at *10:00 A.M. on Tuesday, April 12, 1994* in room SD–215 of the Dirksen Senate Office Building.

"The Committee will focus on the way Medicare should be treated under health reform," Senator Moynihan said in announcing the hearing. "We will examine specifically the anticipated effects of Medicare budget cuts proposed in a number of major health care reform plans."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished witnesses and to our guests. Welcome back to these hearings. Senator Packwood and I have been talking about this. For those who keep track or want to keep on track, we have been thinking we would finish our hearings about the second week of May. Is that right, sir? So everybody will have every subject they wanted.

Senator PACKWOOD. The Chairman has been very good, I think, about allowing any member who had somebody rational to call as a witness to let them appear. If we finish by May 15 and start mark-up by the middle of June, I still think we will be ahead of the House.

The CHAIRMAN. There you are, as is only fitting. I would like to note for the record that on February 23 our distinguished former colleague Leon Panetta appeared before the Finance Committee and informed us that the administration would have a welfare re-

form bill before us on April 1. Senator Dole was irreverent enough to suggest April 2 and it is now April 12 and with nothing in sight.

This morning we have a group of very distinguished witnesses to talk about Medicare matters for us and it comes in the wake of the report of the Trustees of the Social Security Trust Fund which was released yesterday, reported in this morning's press, and which makes a very powerful statement about the growth of Medicare.

I have a table from the report which I will put in the record, which shows that between now and 1999 the average annual rate of growth of Medicare will be 10.6 percent. That is a rate that doubles every 7 years. Dr. Podoff having taught us as best he can the rule of 70.

The estimate is that after health care reform the rate will drop from 10.6 to 8.9. Well, that doubles every 8 years, which is a pretty phenomenal rate, and a much higher rate than would be expected for health care costs generally.

Senator Packwood suggested to me that these are not that bad after all. The world will not come to an end until the year 2001. I think I suggested that a millennia ago they thought the world would come to an end at the year 1001, so it just shows there are continuities in all these things.

But we do find extraordinary growth rates projected in the near term and long term and they are the subject, among other things, of our hearing this morning.

Senator Packwood?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, I was elected to the Senate in 1968. So I started in January of 1969 and we were then, of course, accepting of the President's budget for the fiscal year 1970. And in 1970 the Medicare outlays totaled $7.1 billion.

Even if we had followed the theory that you just announced about doubling every 8 years, we would still be only at about $70 billion now. We dramatically increased beyond that.

And as I look at Medicare projections I am reminded a bit—I cannot remember the name of the theory, Mr. Chairman, but it is the one that says, the universe is ever expanding. It is not finite; it is infinite. It continues to grow no matter what. I think that is what Medicare is. It is an ever-expanding universe that never ceases to grow.

And always in the past we have underestimated its growth. We have usually overestimated the savings we hoped we would achieve. Not always, but usually we overestimated the savings and we underestimated the cost. One of the debates we now have is whether or not we should expand health benefits in any bill that we pass, including Medicare benefits, including some prescription drugs in outpatient, in Medicare.

I am willing to look at those, Mr. Chairman, but I want to look at them very carefully. It is almost impossible to take back benefits once you have given them. It is one thing not to give them, but once you have possessed it and once it is in your hand, then it becomes a right and you feel deprived if you lose it.

So before we jump in to any new benefits, I hope we are as sure as possible that we can estimate the costs, remembering we've always been wrong, and that we have revenues to pay for it. And if we do not have the revenues, we have not bellied up to the bar and voted for the revenues, then I would hope we would reform the health system, pass a health bill, but be very hesitant about new entitlements that we do not know the cost of and do not know if we can pay for it.

The CHAIRMAN. Fairly said. If I could just make a point from a recent issue of Fortune Magazine. When you came to the Senate, sir, the life expectancy in the United States was 71 years. Today it is 76. I mean, those are momentous changes in something that is fundamental. Life expectancy for American women is now at 79.6 years. So these things change right before your eyes, much less in very alluvial terms.

Senator PACKWOOD. Well, and as I recall, those life expectancy figures grow at both ends. Part of the increase is the fact that we are being more successful in keeping younger babies alive and younger people alive. So that is a factor, but I would like to see the figures of what is the life expectancy in 1968 or 1969 of those who were then let us say 65 and what is the life expectancy of those who are 65 now. I bet you the figures would be even more startling.

The CHAIRMAN. I see Mr. Davidson nodding knowledgeably. We look forward to hearing his view on the matter.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman. I have no statement.

The CHAIRMAN. Senator Durenberger?

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you. I have a statement I would like to be made a part of the record and two observations. One, I thank you as our ranking member did for inviting us to invite on behalf of the committee, rational witnesses. I have one today from Minnesota, Mr. Halvorson; and others who I know well and I will vouch for their rationality as well.

The second observation is Robert Pear picked up the trust fund and, of course, that is sort of easy to measure and easy to express in our speeches. But the reality is when you go out and you listen to doctors talk about health care reform or react to the talk about health care reform, they always say, well, we are only 19 percent of the problem or 20 percent or something like that. Why do you beat up on us? The answer is, because they determine about 90-some percent of the spending.

We are not beating up on them either. But the reality is, when we did the DRG system here in 1983 we brought a rationality to the definition of hospitals. And the definition of a hospital today is no longer what it was in 1983.

The question is, has the definition of what doctors do and how they do it, how has that changed in this period of time. We know from the evidence that the cost growth or the expenditure growth in Part A, the hospital trust fund, between 1980 and 1991, grew

1.78 times while the growth in Part B, the medical expenditures, grew 3.15 times.

We also know that Part B, just in the last 5 years, grew 23 percent faster than the economy. I know that is not doctors' personal income and nobody here wants to beat up on doctor personal income. But it is the way in which we are utilizing the system.

So this is nothing compared to what is happening in Part B unless we are willing to tackle the issue of more appropriate incentives on the part of physicians to use the system or help us use the system more appropriately.

[The prepared statement of Senator Durenberger appears in the appendix.]

The CHAIRMAN. Very much to the point. One of the things I think we have become aware of in these hearings is what enormous transformations keep happening, as if a great economic transformation is underway. The use of hospitals is very different today than it was just 10 years ago. What Schumpeter called the creative destruction of capitalism is to be seen everywhere or so it's my impression.

Senator Grassley?

Senator GRASSLEY. Mr. Chairman, I have no opening statement. Thank you anyway.

The CHAIRMAN. Thank you, sir.

And so we turn to our most illustrious witnesses, each of whom is going to tell us more about life expectancy. Mr. Corry, you are first, sir, as Director of the Federal Affairs Department of the American Association of Retired Persons.

STATEMENT OF MARTIN CORRY, DIRECTOR, FEDERAL AFFAIRS DEPARTMENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Mr. CORRY. Thank you, Mr. Chairman and members of the committee. The comments which a number of you have addressed in these preceding few minutes remind me that in 1983 when the current Chairman and the then Chairman Senator Dole, managed a rescue of the Social Security program, they included in that very comprehensive bill, along with Senator Durenberger's help and other members', a resolution of the Medicare Part A impending insolvency.

As you all remember, in 1983 Part A, the HI Trust Fund, which is reported today, was supposed to go belly-up in 1987. This committee, and your colleagues in the House, have rescued the program, if you will, probably more times than you care to remember. But in each case the careful stewardship of this committee and your colleagues in the House have moved that program forward in a constructive way.

Clearly that is going to be a challenge as we look at the whole issue of health care reform and maintaining the Medicare program as a viable program for older Americans and disabled Americans.

Here inside the beltway Medicare is $150 billion and thousands of pages of statute and regulations. But to real people beyond the beltway, older and disabled Americans, Medicare has been their health plan for the last 30 years.

They have relied on this program as the mainstay of their health care, even though there are large gaps in that program today. Medicare beneficiaries today pay as much or more out of pocket than they did when the Medicare program began. It is, however, a very successful program. The administrative costs of the program are exceedingly low, in the range of 2 to 3 percent, particularly relative to the private sector.

The Medicare program works and clearly much of the concern that I suspect some of you may have heard during the recess from some of your older constituents reflects the fact that for all of its faults, blemishes and warts, Medicare beneficiaries value this program. Their families, including the younger members, value this program.

Medicare pays about half of all Medicare beneficiaries' total health care costs today. There are some major gaps. The first, obviously, being long-term care. But we would be short-sighted if we did not recognize that the costs of long-term care do not fall only on older persons. Indeed, both the financial as well as emotional costs fall on younger and middle-aged members of older persons' families.

Family members are most often, as you well know, care givers. In fact, most care-givers tend to be women. They not only bear the burdens of physically providing the care, but also important economic burdens in reduced pensions, and in reduced Social Security benefits later in life.

Prescription drug coverage is an area that is particularly important to older Americans as well as younger Americans, given just the sheer advances in medicine. You spoke of the shift in some of the costs from hospital costs in Part A to Part B. Some of that is clearly a conscious shifting of costs as hospital cost containment has ratcheted down. Some of it is the advance of medicine.

Care which 10 years ago was provided in a hospital is today provided in an out-patient setting and with pharmaceuticals. The fact of the matter is, the lack of a pharmaceutical benefit in the Medicare program today means that the health care provided is less effective than it otherwise would be. It results in too many cases in hospitalization for more acute incidents.

The CHAIRMAN. Mr. Corry, could I just ask you if this is the case?

Mr. CORRY. Certainly, Mr. Chairman.

The CHAIRMAN. About 10 years ago, before some of the new pharmaceuticals came on line, about a quarter of operations in hospitals involved peptic acid diseases, did they not?

Mr. CORRY. A very significant amount. I do not recall the number. I will take your word for it.

The CHAIRMAN. Yes, in that range.

Mr. CORRY. Yes, sir.

The CHAIRMAN. Those have all but vanished now.

Mr. CORRY. That is but one example of where advances in medicine today do not require hospitalization or if they require utilization of hospital facilities it is in an out-patient setting or with prescription drugs.

The AARP has commended the President, as well as the sponsors of his legislation here in the Senate, as well as in the House, for including prescription drug coverage and a beginning at home and

community-based care in the President's proposal. We commend these to others who are working diligently to try to fashion, on a bipartisan basis, a health care reform bill that will pass muster not only here in the Congress but also with the American people.

Finally, Mr. Chairman, I would just say, as I think the members of this committee know, AARP has been supportive of managed care programs in the past and will continue to in the future, as an option which ought to be available to all Americans, old and young alike.

We would, however, take strong objection to a situation in which Medicare beneficiaries would be herded into managed care over their objections. We believe that it can play a useful role. It can help foster some competition. But ultimately we believe that if health care reform is going to address the really fundamental issue that has been driving public opinion on this issue for several years, we will have to confront the issue of controlling costs systemwide, not only in Medicare.

This committee knows full well how difficult that job is. But if we continue to only reduce spending in the Medicare program from what it otherwise is projected to be, we will continue to see cost shifting to the private sector and we will see an increase in a disturbing trend that we are hearing more about every week from our members, and that is real threats to access for Medicare beneficiaries.

So with that, Mr. Chairman, thank you. I look forward to any questions from the committee.

[The prepared statement of Mr. Corry appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Corry. We are not going to use our lights this morning. But if panelists could be concise enough, we will all get a chance to have an exchange in the aftermath.

So, Mr. Davidson, we have been talking about your hospitals with great abandon until now. Here is your chance, sir.

STATEMENT OF RICHARD J. DAVIDSON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. DAVIDSON. All right. Thank you, Mr. Chairman, and good morning. My name is Dick Davidson and I am the President of the American Hospital Association and I am pleased to be with you today to offer testimony on behalf of the nation's hospitals which I think you have acknowledged have changed rather dramatically in the past decade and are in for a lot of change over the next decade; and it is change that we will advocate and help bring about. I want to say that right from the beginning.

Let me say as strongly as I can, hospitals support reform. We have praised President Clinton for providing the leadership and initiatives to put the issue on the table so that it can be debated openly and honestly. We support significant change and we have been advocating dramatic change since the fall of 1991 and I will talk about that in a little bit.

Our reform vision, the way we see the future, in terms of health care delivery and financing is pretty pragmatic. First, we think every American ought to be guaranteed access to health insurance coverage.

Second, we believe it is important that if we expand access that we not expand access into this delivery system, which is fragmented, uncoordinated. In our view, it is broken. It is important that we move into a new delivery system where care is coordinated and we can do a much better job.

And our third practical approach is that we have to have fair financing. We do not pretend there are no financial consequences of expanding access to all Americans. And our vision calls for very tough economic discipline for providers, using fixed payment. We are supportive of a fixed payment, a capitated payment methodology that will provide new kinds of incentives to change behavior of not only hospitals and doctors, but to also bring about a change in the capacity of the nation's hospitals. We need to deal with that and we need to deal with that soon.

Moreover, our vision calls for more behavior change, in our opinion, for hospitals than any other proposal that is being discussed by the Congress. I just want to repeat that again. We think we are calling for more behavior change by what we advocate than any other proposal before the Congress and that is key. We must have behavior change.

But, Mr. Chairman, unfortunately, we are not here today to talk about reform. We are here, I guess, to talk about kind of the same old, and if you will excuse me, the same old stuff. That is, Medicare spending reductions. No matter which way we go we always find ourselves in that dilemma talking about Medicare spending reductions and I think we ought to acknowledge right up front that is not reform. That is not reform. That is not even business as usual.

In fact, in our view, it is worse than business as usual. Medicare is already underpaying for the care for its beneficiaries, as we treat them in hospitals. You have seen the numbers.

PROPAC, which is your own official advisory panel, states that today Medicare pays only 88 cents on the dollar for hospital care. And what is most sobering is that nearly every major health care proposal before the Congress, whether it be Democratic or whether it be Republican, calls for substantial reductions in the Medicare program, and at as much as twice the level of any previous reductions in the history of the program since 1965. That is significant.

So we come here before you today, Mr. Chairman, with the results of a study that we asked the consulting firm of Lewin-VHI to produce on the effects of such Medicare reductions on hospitals so that you have some sense of what we are all up against.

Let me begin by saying that these study results are not predictors of the future, but they are illustrations of the kind of pressures that hospitals face if such Medicare spending reductions alone are enacted. We have been talking about those kinds of reductions year after year and we always fear that that is a kind of action that could take place without reform.

So I would like to share with you some of the key findings in our study. By the year 2000, which is only 6 years away, Medicare could be paying as little as 71 cents on the dollar for care given to Medicare in-patients—71 cents.

The CHAIRMAN. Does that assume any particular bill? Is that the President's bill?

Mr. DAVIDSON. This is modeling the President's bill, Mr. Chairman.

The CHAIRMAN. Modeling the President's bill.

Mr. DAVIDSON. And we only use the President's bill——

The CHAIRMAN. Because others are similar or not dissimilar.

Mr. DAVIDSON. Yes.

The CHAIRMAN. But this is specific.

Mr. DAVIDSON. We only use the President's bill because that had the details available to do this. But as I have said, virtually every major proposal that you are considering calls for similar cuts. So it is not just the President's bill, it is Republican measures as well as other Democratic measures. So we can talk to all sides of the issue and we want to make that very clear.

Such spending reductions could make the Medicare program a worse payer than Medicaid is today. And all of us believe that that is a national embarrassment as it stands today. We could not imagine moving Medicare to being a poorer payer than Medicaid is.

Virtually all hospitals, according to our study, and all States would be affected. Particularly hard hit would be rural hospitals, teaching hospitals, large urban areas and hospitals serving a disproportionately large share of low-income patients.

Let me just note, Mr. Chairman, that in looking at the implications of the study, we are very sensitive to the difficult task that confronts this committee. In essence, you have been asked to deal with the entire problem of health care reform with very narrow financing options available to you. We want you to understand that we understand the dilemma that that puts you in and the tough choices that that presents to this committee.

But faced with Medicare reductions like these and their future, hospitals, too, face tough choices. You know, we do one thing, and we do one thing very well. That is that we take care of people. That is all that we do. And reductions like these would force hospitals to make some very painful choices.

I have to raise these questions with you. You know, we talk about it all the time. When you are faced with the hard choices, what are the decisions that you make? Should we postpone upgrading our facilities? Should we postpone buying the new piece of equipment? Everyone loves the technology that we have. Should we reduce services? When we do that, people get upset. Should we eliminate services that do not carry their own financial weight, like day care for seniors, like community outreach, like wellness programs, like trauma centers, like burn units? None of them carry their own financial weight. We have to find other ways to finance them.

Should we reduce our work force? I mean, we are labor intensive. We take care of people. You do that with people. How far do we go?

Now these are the terrible trade-offs to be made in the face of such reductions and all of them would be felt more deeply than ever by hospitals, our patients and the communities that we serve. And most important—we think this is very significant—these actions, as they are proposed now, would widen the gap between how we pay for and provide care for Medicare beneficiaries versus the rest of the population.

And this is at a time when we are trying to reform the way we pay for and deliver care for all of the people in the United States. And instead we are going to lock the Medicare beneficiaries into a system and widen this gap. This kind of an action takes us in the absolute wrong direction and we can talk about that further.

Let me conclude, Mr. Chairman, by urging that you and members of this committee reject Medicare funding reductions as an acceptable way to finance health care reform. They are not acceptable. Hospitals cannot do reform and pay for it at the same time. These are very tough choices. Thank you.

The CHAIRMAN. Thank you, Mr. Davidson. You could not have been more emphatic and specific. If nothing else comes out of this effort, I think Senator Packwood would agree, that the firm of Lewin-VHI will have prospered. [Laughter.]

I do not know where they are.

Senator BRADLEY. Well, at least it is not Chase Econometrics.

The CHAIRMAN. Yes, at least it is not Chase.

[The prepared statement of Mr. Davidson appears in the appendix.]

The CHAIRMAN. Mr. Davidson has made a very specific statement about an aspect of each of the proposals before us. I hope you would all feel free to comment on it as we go along and we will be asking you questions in just a moment.

And now Dr. Charles Duvall, who is a member of the Council on Legislation of the American Medical Association. Dr. Duvall, we welcome you.

STATEMENT OF CHARLES P. DUVALL, M.D., MEMBER, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC

Dr. DUVALL. Well, thank you very much, Mr. Chairman. It is an honor to be here. Members of the committee, we appreciate this opportunity to testify. I am Charles Duvall. I am a practicing internist right here in Washington, DC and a member of AMA's Council on Legislation and with me is Bruce Blehart, who is the Director of AMA's Division of Federal Legislation.

The CHAIRMAN. Mr. Meishart, is it?

Dr. DUVALL. Blehart.

The CHAIRMAN. Mr. Blehart, we welcome you, sir.

Dr. DUVALL. The American Medical Association believes that the Health Security Act holds out the promise of increased opportunities for both current and future Medicare beneficiaries to receive care through the private sector.

However, coverage should be at least equal to Medicare's current levels in order to be consistent with this promise. That is why the AMA supports the major principles involved in S. 1757, S. 1770, and S. 1575 and in their shared recognition that Medicare, indeed, is a unique program of health care coverage that must be preserved intact.

In addition, we also support giving beneficiaries enhanced coverage options through the private sector. Individuals should have the freedom to chose the plan, public or private, that best meets their own peculiar needs.

Senator ROCKEFELLER. Do you think they have that freedom today, sir?

Dr. DUVALL. I think it can be expanded, Senator.

Senator ROCKEFELLER. Do you think they have it today, to the extent that the American Medical Association talks about people having freedom of choice today to choose? Do you think they have it?

Dr. DUVALL. I think they do today, yes.

Senator ROCKEFELLER. I do not think they do. We will talk about it later.

Dr. DUVALL. All right. One potential direction for the future as developed by the Health Subcommittee of the House Committee on Ways and Means is to use a new Medicare Part C as a vehicle to provide coverage for the uninsured, the unemployed and for those working in this Nation's small businesses.

While the AMA endorses universal coverage, we do not support achieving it through a vast expansion of Medicare. Rather than create a massive and expensive new entitlement program, we believe a better approach would be to expand coverage through private sector reforms, including insurance reform, risk pools and integration of Medicaid and uninsured populations into already existing private plans.

Recent budget-driven history illustrates why we question the wisdom of achieving universal coverage through Medicare expansion. On top of a decade of program cutting, enactment of so-called savings proposals in S. 1757 would result in $124 billion of further Medicare "savings" through the year 2000. But this would be achieved at substantial human cost and the program would deteriorate further and undermine the very fundamentals of physician payment reform.

This committee, and especially Senators Durenberger and Rockefeller, have had a vital leadership role in developing physician payment reform and we are pleased that you will also be having an essential role in crafting our new health care system.

We are concerned that these proposed future massive cuts send exactly the wrong signals about the degree to which physicians and other Americans can expect their government to honor commitments made as part of this kind of legislative process. These proposals can only be seen as instituting an unwarranted overhaul of the Medicare RBRVS and they inject instability and complexity into that system which was, indeed, instituted to provide just the opposite effect.

They promise to dramatically accelerate a downward spiral of Medicare physician payments. With the PPRC telling us that Medicare pays 59 percent of what private payers allow for the same service, and with primary care office overhead approaching 50 percent, the pressures for cost-costing are evident and will be even stronger if these proposals are enacted.

It only stands to reason that we have strong and profound concerns about the broader implications of these cuts. It bears noting that virtually none of the administration's proposals for Medicare program cuts are even mentioned in the CBO just-issued report on deficit reduction options.

Finally, as the chart attached to our formal statement illustrates, these are truly draconian proposals.

In conclusion, Mr. Chairman, we want to leave you with a clear understanding that the American Medical Association staunchly supports actions to reform our health care system. However, this restructuring should be done in a manner that builds on what works in this system. It should be a reform, not a total transformation. Medicare beneficiaries should have enhanced options beyond government-structured health care coverage.

Furthermore, it makes little sense to finance health care for one segment of the population by stripping funding from another, such as Medicare. Finally, the AMA will continue to support the ability of our patients, most especially our patients who are Medicare beneficiaries, to have free choice of coverage options and access to health care services only of the highest quality.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Duvall appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Duvall.

Senator Durenberger, would you like to introduce our concluding witness?

Senator DURENBERGER. Well, Mr. Chairman, other than rationalize there are lots of things I could say about George Halvorson. But he has recently written a book. Somebody has it here. I do not want to wave it around because we are not lugging things.

The CHAIRMAN. No, there is a copy right behind. Wave it around. [Laughter.]

The CHAIRMAN. It is called Strong Medicine.

Senator DURENBERGER. All right, Strong Medicine.

But George comes from a small town in rural northwestern Minnesota, which is probably very much the same today as it was when he left. He associated with an institution which many people in medicine took pains in the 1930's to fight and to try to stamp out something called Group Health.

Today things have changed dramatically and Group Health is now Health Partners. He does not come here to describe his institution. But largely from a State like Minnesota and probably representing some of the cultural ethic, if you will, of the upper Midwest, he can describe for you what people in a cooperative mode—as opposed to an alliance mode or you can use different names—but just sort of a sense of the spirit of cooperation, but what people who are both consumers of health care and providers of health care can do if properly motivated.

I trust that one of the things he may comment on is that when we tried this in the Medicare program with our colleague John Heinz under TEFRA risk contracting, we proceeded to try to destroy the mood of cooperation by inappropriate payment systems.

There is hope for the future. I introduced the legislative vehicle for that hope a couple weeks ago. Reintroduced it. I guess I introduced it originally back in 1985. But I do not know anyone who can speak more articulately for not just Minnesota but the North Dakota that Kent and I spent time talking in last week, South Dakota, just generally our part of the country than George Halvorson.

The CHAIRMAN. Well, on that note, you are cautioned to be rational at all times, Mr. Halvorson. We welcome you, sir.

STATEMENT OF GEORGE C. HALVORSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HEALTH PARTNERS; AND CHAIR-ELECT, GROUP HEALTH ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. HALVORSON. Well, thank you, Mr. Chairman. Thank you, Senator Durenberger, for that wonderful introduction.

I do have the honor as serving as the President and CEO of Health Partners, a 600,000 member consumer-governed not-for-profit HMO in Minnesota. And I also have the honor of serving as Chair-Elect of the Group Health Association of America at this point and my primary testimony witness today will be on behalf of GHAA.

We at Health Partners, however, participate actively in the Medicare program, both in the risk program and as a social HMO. So I can speak from that experience as well. I am testifying today on behalf of GHAA, who has 350 health maintenance organization members with 33 million members, who account for about 75 percent of the total HMO enrollment nationwide. About 90 GHAA member plans have risk contracts with Medicare programs. This represents 77 percent of the plans who participate in Medicare; and 92 percent of the enrollment in the risk program. Our members also participate in the program under cost-based arrangements. I am particularly pleased to be here today to talk about the role of HMOs in the Medicare program and in health care reform.

HMOs provide comprehensive, high-quality care to more than 45 million members nationwide and approximately 2 million Medicare beneficiaries. We focus on keeping people well by covering important preventive services and limiting out-of-pocket costs so that members are encouraged to see their personal physician wherever necessary.

Consumers consistently give HMOs positive reviews, which are reflected in our high enrollment and our extremely high re-enrollment rates. Today about 45 million people, or roughly one out of every five Americans, who has health insurance is enrolled in an HMO by their own personal choice.

GHAA estimates that the HMO enrollment will exceed 50 million by the end of 1994. HMOs promote quality of health care in many ways, including careful selection of providers based on professional qualifications and interest in working within a medical team.

Eighty-five percent of HMO physicians nationwide are board certified, compared to only 60 percent of all physicians nationwide. HMOs not only treat sickness, but they also make a unique contribution to promoting health.

Speaking for a moment on our own health plan, our plan, for example, has made a commitment to work in partnership with its members to reduce the incidence of heart disease, diabetes and a number of other health care conditions by 25 percent over the next 4 years.

The CHAIRMAN. The next 4 years?

Mr. HALVORSON. In the next 4 years by focusing on the health of our population.

Medicare beneficiaries who enroll in HMOs are already realizing some of the central goals of health care reform. They have access to affordable high-quality comprehensive benefits in exchange for a

fixed monthly premium. HMO coverages for Medicare beneficiaries tend to be very affordable.

Over 42 percent of the Medicare beneficiaries are charged a premium for their HMO coverage of less than $20 per month. The HMO premium covers the Medicare enrollees' deductibles and coinsurance; and if you would take a look at average costs, the annual out-of-pocket costs for seniors who enroll in HMOs are about $600 per year less than the average costs for seniors under traditional Medicare.

A recent study of HMO Medicare beneficiaries showed that HMOs increased seniors' access to care and that about 90 percent of HMO members rated their HMO care as good or excellent. Fourteen out of fifteen HMO members would recommend their HMO to a friend or family member. We consider that to be a key indication of satisfaction.

I mention all of those virtues of HMOs as a preamble to saying that as health care reform goes forward we strongly believe that all Medicare beneficiaries should have a chance to choose among delivery systems and that expansion of the availability of HMO membership to seniors should be an important aspect of this right to choose.

We believe that Medicare contracting opportunities for HMOs, although the cannon should be improved, have created a solid foundation for the future. From this experience, several elements can be identified that we think will be important for the future, regardless of the context of Medicare and health care reform.

What is important to realize is that, despite the overall growth in the number of people in the U.S. who are receiving their health care through HMOs, there has not been the parallel growth in the number of Medicare beneficiaries enrolled in HMOs. This has been primarily due to the relatively low number of HMOs who have chosen to participate in the Medicare program, and it is not due to consumer reluctance to join Medicare HMOs.

Consumers join HMOs when and where they are offered. However, only one-fifth of the HMOs in this country are currently participating in the Medicare program.

The CHAIRMAN. Does this reflect the payment rates?

Mr. HALVORSON. This directly reflects the payment rates. The payment approach that is available through Medicare is inadequate, inconsistent, unpredictable and inequitable. And, it is the major reason——

The CHAIRMAN. Are there any other——[Laughter.]

Mr. HALVORSON. And other than that, it is a fairly good system. [Laughter.]

Mr. HALVORSON. That is the direct cause. And inadequate rates are——

The CHAIRMAN. That is about as much incendiary talk as you get from a Swede. [Laughter.]

Mr. HALVORSON. Mr. Chairman, at the risk of correcting you, a Norwegian.

The CHAIRMAN. Sorry, sir. [Laughter.]

The CHAIRMAN. A profound mistake in that part of the world. I do apologize.

Mr. HALVORSON. A distinct difference.

Several bills have been introduced that would change the current risk contracting methodology and I would like to make a couple comments today about the bill that Senator Durenberger has just introduced, the Medicare Choice Act of 1994 and two quick comments about the administration's Health Security Act.

We are pleased and not at all surprised that Senator Durenberger has given improvement of the Medicare risk contracting program a high priority and that he has introduced the Medicare Choice Act of 1994. That bill incorporates some important principles of consumer choice among delivery systems for beneficiaries. It calls attention to the need for comparative information on health plan offerings that will permit Medicare beneficiaries to make truly informed choices for the first time.

In addition, it acknowledges that the reimbursement mechanism must be improved in order for HMO options for Medicare beneficiaries to expand. We look forward to working with Senator Durenberger and his staff to ensure that a mechanism is developed to allow Medicare beneficiaries to compare the values of the various options available.

Now, relative to the administration's bill, while we find significant areas to support the administration's bill, such as the comprehensive benefits and the universal coverage, GHAA opposes the provisions that would add an arbitrary ceiling and floor to the AAPCC payment methodology. We believe that provision would drive HMOs away from Medicare rather than attracting HMOs to it.

The reduction that would result from the application of that arbitrary ceiling is inequitable because it is proposed in combination with the compounding reduction that you have already heard about from other speakers, a compounding reduction in the fee-for-service Medicare payments that create the AAPCC.

The AAPCC is a formula based on those payments and the administration's proposal is to reduce those payments, and on top of that, reduce the result. In other words, this reduction would unfairly penalize risk contracting HMOs. GHAA also opposes the proposal in the administration's bill that would establish an outlier pool for high-cost cases. That would be funded also by reducing the AAPCC.

The fact is that the outlier pool is not necessary. Commercial reinsurance is available to HMOs who need it and HMOs with sufficiently large enrollment self-insure. A primary impact of that provision would be to increase administrative costs for the government and for the HMOs and it would discourage HMOs from working with Medicare.

In conclusion, I would like to say that under health care reform, regardless of how the Medicare program is treated, there should be a strong commitment to offering Medicare beneficiaries a choice of delivery systems. HMO Medicare beneficiaries should continue to enjoy the same advantages of HMO membership as other HMO members, including high-quality, affordable comprehensive health services.

GHAA and I look forward to working with the committee and with Senator Durenberger and staff to do anything we can to further this cause. Thank you, Mr. Chairman.

The CHAIRMAN. We thank you, Mr. Halvorson.

[The prepared statement of Mr. Halvorson appears in the appendix.]

The CHAIRMAN. I know that Senator Rockefeller will probably want to speak to some of these points as well. Could I just make one query? Earlier on I commented on—and Mr. Davidson was very emphatic about this—the extraordinary transformations in medicine that are going on right before us. The introduction of pharmaceuticals that dealt with peptic acid disease has dramatically reduced the operations that perhaps made up a quarter of all medical operations in hospitals and changed the stay in hospitals—Dr. Duvall is acknowledging—in the course of a decade. And you said something casually which Senator Bradley picked. The idea that you were undertaking a 25 percent reduction in heart disease, diabetes, and I think you mentioned one other affliction.

Senator DURENBERGER. Pre-term birth.

Mr. HALVORSON. Pre-term birth is another. Right.

The CHAIRMAN. Yes, sir. In 4 years.

Mr. HALVORSON. Yes.

The CHAIRMAN. Among your 50 million people. That is a language you could not talk 20 years ago. Is this in part due to to the advent of pharmaceutical treatment of some kind? I believe in the case of heart disease there is that effect taking place, is there not?

Mr. HALVORSON. Mr. Chairman, the medical science of prevention has made huge progress in the last several years. We now have a very good sense of exactly what causes heart disease for most Americans. We have a good sense of who is at high risk for diabetes and things that can be done to prevent that. We have a much better sense of what the indicators are that someone is at risk of premature birth.

What we are doing is identifying people at high risk in each of those categories and intervening in their health prior to the time that they have the heart attack or they become diabetic with the goal of working in partnership with them to move them back down the risk spectrum to a lower level of disease.

The CHAIRMAN. This is almost a new field of medicine; is it not?

Mr. HALVORSON. It is almost a new field of medicine, and it is clearly where health care needs to go.

The CHAIRMAN. Right before your eyes. Yes, right before your eyes. As we say primum non nocere, we do not want to get in the way of that. Thank you very much.

Senator Packwood?

Senator PACKWOOD. Mr. Corry, AARP opposes means testing of Medicare; is that correct?

Mr. CORRY. Opposes it, yes, sir.

Senator PACKWOOD. Yes. Why do you oppose it for Part B where the general fund is picking up about 75 percent of the cost and we means test lots of other things? Why should we not means test at least that part of Medicare?

Mr. CORRY. Senator, Medicare, whether it is Part A or Part B, is part of a social insurance system in this country in which individuals pay in throughout their lives with the expectation that they will be eligible for benefits upon either reaching age 65, being disabled, or other specific criteria.

What the Association has said repeatedly, as you know, the members of the committee know, is that to means test the program, that is in the form sense to turn it into a Medicaid-like welfare program would harm public support for the program.

However, we have been, as you know, very supportive of progressive financing; sometimes almost to a fault. The Medicare program like Social Security involves both a combination of payroll taxes and progressive financing. In the case of the Part B program, individuals pay in their Part B premiums which finance currently 25 percent of outlays.

Higher income older Americans, those really even in the middle income range, pay significantly more into Medicare Part B than do lower income beneficiaries because they pay income taxes. That is, they are helping support the other 75 percent.

When you add the fact that as a part of the 1993 Budget Act, Congress included increased taxation of Social Security up to 85 percent above certain thresholds——

Senator PACKWOOD. I cannot remember, was AARP opposed to that, the means testing of Social Security?

Mr. CORRY. We have opposed means testing Social Security or Medicare. We worked with this committee in 1993 to try to fashion a fairer provision relative to the increased taxation of Social Security. We did not support the President's proposal on that. We worked with the Chairman and other members of the committee to address that.

Senator PACKWOOD. Let me rephrase it. Do you consider what we are now doing to Social Security in the sense if you have enough income you are going to pay part of the taxes, do you regard that as means testing?

Mr. CORRY. We have made a very clear distinction as we believe our members do, and the general public does, between progressive financing—what one pays in to support a program versus an outright means test, ala welfare program. To do the latter is to seriously harm support for the program. To do the former is consistent with tax policy as well as our general approach to public subsidies. That is that they should be financed on a progressive basis.

Senator PACKWOOD. It is OK to means test it going in, but not means test it coming out?

Mr. CORRY. I would not say it is OK to means test it going in. What we have supported is progressive financing.

Senator, I am not playing semantic games with you here. It is a very important distinction.

Senator PACKWOOD. All right. I am not sure I agree with you, but I understand the distinction.

Let us assume that we are going to try to pay for whatever benefits that we are going to add and we just do not have the money. So we say, OK, we just leave Medicare alone. Just leave it the way it is. We do not want to add prescription drugs or anything else. We will not phase it in. We will go ahead and pass the health reform bill ex-Medicare. Would AARP support that? Assuming you like the bill, would AARP support that?

Mr. CORRY. Ultimately, that is a decision which our Board will have to reach. What our Board has said consistently over the past several months—and Senator Moynihan visited with a number of

our leadership back in late January—is that we believe that inclusion of long—term care in particular is fundamental to the support of older Americans.

The point here I think is really beyond whether or not AARP supports or endorses any plan. We have been working with our membership for the last 5 years to try to educate them about some of the problems in health care, not just in Medicare, as well as some of the trade-offs, some of the very difficult options.

We believe that every public opinion poll, every piece of data we can get our hands on, both quantitative and qualitative, shows very clearly that across all ages, not just for the aged, inclusion of a long—term care program, dramatically increases support for health care reform because it addresses one of the cost fears that people have sitting around the kitchen table.

The issue of cost in health care reform is the glue in that debate, both at the macro level as well as at the level of the kitchen table.

Senator PACKWOOD. Is that the end of the answer?

Mr. CORRY. For now.

Senator PACKWOOD. It kind of abruptly stopped. I am still not sure I understand the answer. Are you saying that some start toward long-term care is almost, even if it is a modest start, is almost a quid pro quo for AARP to support any health reform bill?

Mr. CORRY. What I am saying, Senator, is what our Board has said, which is that inclusion of a long-term care program is fundamental to the support of older Americans and, based on public opinion data across all ages, it is critical to the support of people of all ages.

When you include a provision for home and community-based care, it dramatically increases support for health care reform. That is as far as I can go with you today, Senator.

Senator PACKWOOD. There is no question about that. If we include prescription drugs, it expands the support for it even further. The more we add, the more support there is.

Mr. CORRY. I would say, Senator, that clearly when older Americans as well as their families look at a benefit package in health care reform, they view that as part of—not the entire equation but part of—the equation in dealing with the problem of costs that they confront.

The comments of some of the other panelists and the Chairman about the changes in behavior and personal responsibility are equally important. We find among our members, and particularly among our younger members—half of our members are under 65—that there is a growing awareness that personal responsibility helps to reduce health care costs. It is not simply a matter of the government regulating. Each individual bears some responsibility to stay healthy and that is really a changed environment from even just a few years ago.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Could we agree that the AARP is the A-A-R-P and not "arp."

Mr. CORRY. Thank you, Mr. Chairman. We could.

The CHAIRMAN. There you are.

Senator BRADLEY. Arp was a great artist.

The CHAIRMAN. Arp was a great artist says the Senator.

Senator GRASSLEY. ARP is an agricultural subsidy. [Laughter.]

Mr. CORRY. I am learning more each minute.

The CHAIRMAN. Therefore, organizations are called what they wish to be called in this committee.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

As I understand it, the AMA and the Hospital Association and AARP essentially opposed these Medicare reductions because they cannot make ends meet if these proposed reductions go into effect. That is taking no other factors into consideration.

Of course, a major other factor is Medicare cuts in the context of health care reform, particularly under the President's plan or under other bills that are proposed here. That is, individuals will have health insurance. They will get vouchers, or something, to pay for health care. A lot of hospitals today face the problem of charity care and I can understand it. If there are Medicare cuts to hospitals, that puts greater pressure on charity care, maybe even less charity care.

But, of course, all of this again is the context of other provisions that we are talking about here. I wonder if you could address that, Mr. Davidson, particularly in the President's plan—theoretically all patients would have health insurance, would be paying health premiums to the alliance, to the plans and therefore to the hospitals.

Mr. DAVIDSON. Well, the cuts that the President proposes on their face are not connected to anything in terms of behavior change as well. And, in fact, the President's plan does not call for changing the delivery system for people who are enrolled in the Medicare program. Meaning, there is an expectation that somehow we will be able to extract savings, pay providers less, and yet not change the behavior of the patients in those programs.

So we start at the outset saying that if we are going to extract any savings in Medicare, and there are certainly some savings to be extracted, by changing the incentives and changing the behavior of an awful lot of people, if we go down that path, there are some things that can happen. But the President's plan does not propose this.

None of the plans before the Congress propose this until Senator Durenberger's proposal for a choice.

Senator BAUCUS. Sorry, do not propose what?

Mr. DAVIDSON. Integrating the Medicare program into new delivery systems. As Mr. Halvorson was calling for, we need more incentives to have people who are in the Medicare program move to integrated delivery systems.

Senator BAUCUS. They keep saying that Medicare under the President's plan people would have health insurance. So there would be less need to cost shift in the hospitals and second, there would be less burden on Medicare or private pay patients who do not now have insurance to buy the resources for the charity care.

Mr. DAVIDSON. Senator, everyone would assume that if you are going to have more flow of money to pay for care for people who did not have the ability to pay before, you can then extract cuts on the other side.

The fact of the matter is, if you listen to those numbers, if we pay 71 cents on the dollar for treating senior citizens and you pay

88 cents or 82 cents for treating medically indigent patients, and then ultimately the remainder of your patients, even those who could not pay before, let us say pay 100 cents on the dollar, we are confronted in the hospital community with fixed-based contracts, managed care contracts, that are all at cost or negotiated discounts.

All of this does not add up, meaning, it does not come out to 100 cents on the dollar when you put them altogether. So everybody cannot get it at a discount. Somebody has to pay retail.

Senator BAUCUS. I still do not understand this. If there are a lot of patients today who are charity care, who do not have health insurance, for example, and if under health care reform those people now do have insurance so they are also, therefore, paying into the system, would there not be less need for Uncle Sam through Medicare disproportionate share to provide charity care for hospitals?

Mr. DAVIDSON. We would hope that down the road that there would be less of a need for a cost shift given that segment of our population having an ability to pay. In most cases, that represents about 5 percent of a hospital's annual revenues—some $10 billion in the system in totality. So when you add all of these numbers up, that will help a bit, but it would never take you to a logic that says that you could reduce Medicare payment to 71 cents on the dollar and still have this system work.

Senator BAUCUS. One observation I have is this. I come from a State which is rural. A lot of smaller hospitals have a hard time meeting Medicare needs. Some of them are on the verge of folding. I do not ever see that with large hospitals. Are there large hospitals—I mean, over 250 beds, 500-bed hospitals—in this country that fold, go belly up?

Mr. DAVIDSON. Yes, sir.

Senator BAUCUS. Where are they?

Mr. DAVIDSON. They are in scattered urban areas around the country. In fact, let me address that point. I think it is a very important point, because one of the things that we look at in terms of hospital financial statistics is aggregate margins that represent an apparent, on their face, health of America's hospitals. The last year that we looked at them, 1992, the aggregate margins for the nation's hospitals were roughly 4.7 percent of total margin.

Now that looks like that makes for a healthy hospital system. But there is dramatic differences between institutions. One out of every four hospitals in America is in serious financial trouble.

The CHAIRMAN. One out of every four hospitals?

Mr. DAVIDSON. One out of every four, meaning operating with negative total margins. You can add to that another 25 percent that are on the margin of being in financial trouble at any time. So that if there is no predictability in the payment system, they could be in trouble very fast and our numbers would say that 50 percent of America's hospitals seem to have some degree of stability. But if we keep undermining the base upon which we pay for all of this care, those institutions, too, could be in trouble.

So we have seen, Senator, the closure on average of between 30 and 40 hospitals each year—some small, some larger, some rural, some urban. They are not in a clear pattern in terms of a specific area in the country. We often wonder what keeps New York City

hospitals alive because they have been going from negative margin to negative margin to negative margin.

The CHAIRMAN. So do New York City hospitals.

Senator BAUCUS. I must say though, there is a bit of a difference because in urban settings, if an urban hospital closes or merges or some combination occurs, patients there can always get health care.

In rural America when a hospital closes it is gone. There is no health care. There is no alternative because there is no other hospital. Which leads me to conclude that in rural America because there is every incentive to stay alive, it is literally life and death, that hospital will make every cut, it will make every efficiency to stay alive.

Whereas, in urban settings because patients can always go somewhere else when a hospital closes, a lot of the reasons why urban hospitals close have a lot to do with the efficiencies and inefficiencies, but also have to do with mergers and consolidations and so forth. So there is really apples with oranges.

Mr. DAVIDSON. Well, I think you are right. I think that for rural America what we find, as we see those institutions being in trouble and ultimately closing, there is always an attempt to try to leave something in the community so that there is access at least to primary care and the referral to some other kind of institution.

Senator BAUCUS. The main point I am trying to make here though is, we all get a little worried about Medicare cuts in hospitals. Obviously, there are a lot of other areas where there are going to be in health care far more a lot more dollars coming in.

When we talk about the "devastating effect" that Medicare cuts are going to have on hospitals, I think it is more honest, frankly, to also talk about the other sources of money that offset the Medicare cuts so we get a more realistic picture of what is happening.

Mr. DAVIDSON. I think the danger, Senator, is that if we decide on a starvation strategy to squeeze out capacity, we may squeeze out the wrong capacity meaning the very thing that you said. There may be essential institutions that are on the edge of financial trouble and just by cutting payment across the board for all institutions they may be forced out of business and forced to close. They may not be the ones that you want closed.

Our view is that we have to have a system that has incentives, community-by-community, for people to come together and make a determination about the appropriate levels of capacity through collaboration, working with each other.

In your State we have hospitals looking at developing a statewide network so that there are connections with one another and so there is an ability to move patients from place to place. That is the direction we need to go.

The CHAIRMAN. I think the answer is we discuss both.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you.

Thank you, George, for your presentation. I would like to make one observation about your plan's advertisement—actually I held up the advertisement at a hearing a couple weeks ago and I am glad you gave it some meaning, particularly in light of a reference

earlier to herding people into managed care which we hear about so much.

Health maintenance organizations generally got a bad name and herding is just one of those. But if you think about what George told you in terms of the 600,000 members who have an opportunity not only to maintain their own personal health, but because of the cooperative nature of the ownership, of their individual ownership in this organization, everyone benefits if each person tries to make their contribution toward their personal health maintenance.

This is a two point something billion dollar a year organization. This is no experimental ARP farmer group or something like that. This is $2.38 billion last year, I think, in revenue; 600,000 members and it is for real. It is really happening and it can happen all over America.

The second point is on the importance of what all of these people are testifying to, and Senator Baucus' comments. Last week, I was in Wadena, Minnesota—the Tri-county Hospital there. Wadena County, 20 percent of its residents are Medicare eligible; 30 percent are Medicaid eligible; but 50 percent of the hospital admissions—and I think this is our typical small towns—57 percent of the hospital admissions are paid for by Medicare.

I went through the hospital that night and everybody was over 65. Another 13 percent are Medicaid. While I was ending my visit about 8:00 in the evening, the on-call doctor came down and he said, "I just had to tell you, today I have had 50 calls. The first one came at 3:00 a.m. Seventy-five percent of those calls were from Medicaid persons."

I would guess that 90 percent of them were not urgent emergency kind of calls. This is the way in which our rural hospitals today are being used. So when you hear the reality that Medicaid or medical assistance on the average nationally is paying 72 cents on the dollar and some of our States 40-some cents on the dollar of charges, and Medicare is down to 82 cents on the dollar or 85 cents, whatever Dick Davidson said.

The reality is, there are not many folks left in Wadena to bear the cost shift for the lower payments by Medicare, Medicaid or the over utilization comparatively of the system. I think that is the point that Max is making and the point that each of the witnesses has been making here today in terms of adequacy of the payments.

Now if I can go to the next point, for those of us who come from some of the more conservative practicing States, the average amount per capita for Medicare spending last year was $3,171. In the District of Columbia, that was $4,224. In Minnesota, $2,248 or 29 percent below the national average. I do not have the Utah figure or the Oregon figure, but they were substantially below Minnesota.

Now to translate that, and even within our communities, Hennepin the national average is $3,171 on a monthly basis translating this into what is called the AAPCC, which is the way we try to compute the average cost per month of these payments.

New York City, as we have discussed before, is at $624.41 per month over a national average of $378.13. Albany, New York which is a big city is $341.52. It is actually below the national average. Hennepin County, Minnesota, which is the most populous county

in our State, the City of Minneapolis is there, it is over a million people, $352.10. Right next to it Scott County, Minnesota, $252.27.

People do not sit in Hennepin County and get all their care in Hennepin County or sit in Scott County and get all their care in counties. As we all know, people are getting their care in communities much larger and this kind of disparity and the way in which we continue to reimburse on a county by county or whatever it is basis needs to be dealt with.

And whatever is the appropriate way, and we have talked about this, not just for those of us who come from rural States and sustain the rural hospitals, but because at some point in time in my State it is now the major political issue, is sending our money to other parts of the country where it is not being spent as well as we try to spend it here.

So I think the challenge of universal coverage is to deal with that. If I may, Mr. Chairman, just one question.

The CHAIRMAN. Yes, please.

Senator DURENBERGER. I ask this of George. As it relates to benefits versus services, we are going to be laboring here about how to define benefits and one of the arguments some of us will be making that it would be to everyone's advantage if we gave a definition to the benefit but leave the specific services that flow from that benefit to each of the health plans.

And as it relates to seniors and people with disabilities who are eligible under Medicare, would you describe for us the value in our setting a benefit which is comparable to the current kinds of benefits that we have in the Medicare program, but leaving the specific services that flow from that benefit to each of the health plans if, in fact, people are able to choose a health plan rather than staying in the existing fee-for-service system.

If they stay in the fee-for-service system now, they do not get prescription drugs. There are certain things they do not get. If they could move into an accountable health plan with a reasonable reimbursement system, how might this additional services flow from the same benefit description?

Mr. HALVORSON. Mr. Chairman and Senator Durenberger, I think that is a very important point. The reason it is an important point is because this trick definition of individual eligible benefits can in some ways almost be crippling.

Let me give you a quick example; congestive heart failure in our system. We basically provide all of the care necessary for patients with congestive heart failure. One of the things we have discovered is the benefits of intervening early with those patients we identify who are at high risk of the disease. We basically create a special care plan for them that actually involves us putting scales in their homes and having a nurse call them everyday to make sure that they have not had a weight change. Because if they have a weight change, it is an indication of fluid retention.

Basically, through that type of thing and a series of other similar programs we have reduced the number of admissions to the hospital for congestive heart failure by half for the population we are serving. We have improved the quality of care for those people significantly. We have reduced our cost of care because we do not have to admit these people to a hospital.

The CHAIRMAN. And there would be a corresponding decline in bypass operations?

Mr. HALVORSON. And there is a corresponding decline, particularly in hospitalizations, for that population. There is a cost savings to it, but more importantly there is a major quality of care improvement because we are checking on this population. We can do that in a pre-payment setting. There are no fees for scales. There are no fees for telephone calls by nurses. There are no fees for care plans.

So basically we could not afford to deliver that kind of care outside of a prepayment system. So what we need to do is to be obligated to provide the basic services that the people need, but we do not want an excess amount of restriction on the specifics because it stifles and even prevents creative and effective solutions in many cases.

The CHAIRMAN. That is an important point and we thank you, sir.

Thank you, Senator Durenberger.

Senator Grassley?

Senator GRASSLEY. Mr. Davidson, I think Senator Baucus got at the main point I wanted to get at. I might follow it up with just a few questions. But I cannot do anything more than emphasize what he emphasized, except for a proposition that some might have in this committee that because we have additional revenue coming in under a universal plan by people paying that are not paying today, that that might make up for some of the cuts in Medicare.

I do not accept that or if I accept it, I surely do not think it is going to make up all that lost revenue. But even given that, in a State like mine where we have the third highest percentage of people over 65 and the highest percentage of people over 85, and where we have 92 percent of our working population covered by insurance—8 percent that are not covered—we do not have the leeway in our State that a State that has 15 percent or more—in other words above the national average—of uncovered who will be covered under health reform to make what we would lose in Medicare.

I think that is a given, at least it is not going to be evenly distributed, it seems to me, around the country, if that is the particular case.

In your statement you did mention the negative impact on teaching hospitals, on large urban areas and on communities with hospitals serving disproportionate large numbers of low-income patients of large Medicare reductions. But I do not know whether you meant to leave out Medicare—dependent hospitals.

But just a simple question. Did the Lewin study analyze the impact of the Clinton health plan on Medicare—dependent hospitals?

Mr. DAVIDSON. It looked at all hospitals and they were just a piece of that, Senator.

Senator GRASSLEY. All right. When we were working on legislation to phase out this program, we assumed that a phase-out of the urban rural differential this year in October would make up most of the revenue lost from the phase-out of the Medicare-dependent hospital program. Now I understand that probably a majority of

Medicare-dependent hospitals in Iowa will be driven into the red when they drop out of the program.

Would this be the case in other States as well, do you know?

Mr. DAVIDSON. Yes, sir.

Senator GRASSLEY. It would be.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley.

Can we not all agree we see a problem here that has got to be addressed? You are not going to keep your hospital system paying 71 percent of the costs for a certain class of patient. Something in that arithmetic does not compute.

Senator Bradley, you no doubt have figured a solution to this.

Senator BRADLEY. Yes, I have, Mr. Chairman, but I am going to keep it to myself for the time being.

The CHAIRMAN. Put in play in the last minute.

Senator BRADLEY. Right, the last minute.

The CHAIRMAN. I see.

Senator BRADLEY. Mr. Davidson, you mentioned that you thought that we were unnecessarily constraining ourselves as we think about national health care because we have a very narrow funding base. Each of you—Dr. Duvall, Mr. Halvorson, and Mr. Davidson, I think Mr. Corry—have also talked about the need to change behavior as a way to reduce costs.

What behavior would you like to change? Dr. Duvall?

Dr. DUVALL. I think one of the things we can do besides working with you through the future as things do change in a kaleidoscopic way that other——

Senator BRADLEY. I am thinking of individual behavior.

Dr. DUVALL. I think the incentives that we are seeing with the RBRVS is one good answer to your question, so long as we do not take that payment reform vehicle and destroy it as some of the President's proposals would start to do.

Senator BRADLEY. All right. Mr. Davidson?

Mr. DAVIDSON. Senator Bradley, most Americans are in charge of their own care. They make decisions about who to see. Most of them pick out specialists. Very few people have a quarterback for their care, someone to kind of help them navigate through the system.

We think that there ought to be some form of shared responsibility between individuals and the health plan that they be enrolled in, and that the behavior change there can be helpful in getting people to the most effective mechanisms.

We think we have got to have new incentives that change the behavior of hospitals and doctors and our patients as well. The kinds of things that Mr. Halvorson is talking about are the very kinds of things that we are saying ought to be sweeping America. We have got to have people stopping trying to put each other out of business in the hospital sector and coming together and working in collaboration, focusing on changes in health status in the community.

You know, we do a tremendous job of taking care of people who show up at our door. We have no idea whether we improve health status in the community.

Senator BRADLEY. Now one of the things we have had a number of witnesses come before us and talk about is individual behavior that drives health care costs and the effort to try to change certain individual behavior that drives health care costs.

We had one witness—Mr. Califano came from the Center of Addiction at Columbia University and talked about the tremendous costs that come from use of tobacco. Another person talked about tremendous costs that come from violence and particularly guns in this society.

Now, you know, you are lamenting a funding base that is narrow. Do you support the dollar tax on tobacco?

Mr. DAVIDSON. Absolutely.

Dr. DUVALL. $2, sir.

Senator BRADLEY. $2, OK.

Mr. Corry?

The CHAIRMAN. Do I hear $3?

Senator BRADLEY. Mr. Corry? [Laughter.]

Mr. HALVORSON. You have $3, sir.

The CHAIRMAN. Halvorson says $3. Mr. Corry, bid it up. [Laughter.]

Senator BRADLEY. Mr. Halvorson, I cannot see you but I assume you are still there. I will have to catch you on TV here. [Laughter.]

Do you say yes?

Mr. HALVORSON. Yes.

The CHAIRMAN. He said $3.

Senator BRADLEY. All right. Let me ask you this. So on the retail end you support a $1, $2—you said $3—tax on a pack of cigarettes. What about on the marketing end? Right now across this country there are 16-year-olds and 15-year-olds receiving packets from R.J. Reynolds that advocate Joe Camel, who is sweeping high schools across this country. Sign up with Joe Camel at age 15 and become addicted to tobacco.

Now, the view expressed in some places, here one, that the companies that advertise tobacco should not have a tax deduction. Why should companies that send advertisements to get kids hooked on tobacco have taxpayers subsidize them by giving them a tax deduction? Now, if we eliminate that, let us say we could raise a billion dollars to pay for health care, does that make sense to the AMA?

Dr. DUVALL. Yes, sir. We are strongly in favor of that. We are so much against Joe Camel, the company put a Joe Camel ad up on the building next to our Executive Office Building in Chicago. We would be against continuing that deduction and the very advertising itself.

Senator BRADLEY. Mr. Davidson?

Mr. DAVIDSON. Senator, tobacco, if taken as prescribed, is certain to cause you to be a patient in our hospital at some point. If that can be avoided and it ultimately takes you to death, you have tough choices to make. We would support taxing on tobacco and other actions that are appropriate.

Senator BRADLEY. And removal of the deduction for advertising?

Mr. DAVIDSON. Why not?

Senator BRADLEY. Mr. Halvorson?

Mr. HALVORSON. If tobacco were invented today, it could never legally be brought to market.

Senator BRADLEY. So why should taxpayers subsidize its advertising?

Mr. HALVORSON. Exactly.

Senator BRADLEY. You support eliminating it?

Mr. HALVORSON. Why should taxpayers subsidize any portion of it?

Senator BRADLEY. Mr. Corry?

Mr. CORRY. Senator, I think more than simply looking at tobacco advertising is in order. Yesterday's Times, Sunday's Times, carried the story of direct consumer advertising by pharmaceutical companies. We have heard much from this committee and other committees about whether or not there is induced demand in the area of pharmaceuticals or other areas of health care.

So I think if you address the obviously worthy issue of deductions——

Senator BRADLEY. Does AARP support the denial of the tax deduction for tobacco advertisers?

Mr. CORRY. We have supported your efforts in that in the past, Senator.

Senator BRADLEY. So the answer is yes?

Mr. CORRY. And we expect to continue to.

Senator BRADLEY. Thank you.

The CHAIRMAN. Thank you, Senator Bradley.

Senator Hatch?

Senator HATCH. Thank you, Chairman Moynihan. I appreciate your holding these hearings. According to the Congressional Budget Office the "proposed savings"—I have to put them in quotes because I do not think they are there—would grow from $19 billion in 1998 to $37 billion in the year 2000 and $77 billion in the year 2004.

Most of those cuts, according to the CBO, would be made in reimbursements to hospitals, physicians, and other providers of health care services. Now that is something that causes me a great deal of concern as I know it does other members of the committee.

I am not opposed to examining needed policy changes in Medicare, but I am opposed to arbitrary reductions and I am opposed to them solely for the purpose of providing health care to non-Medicare beneficiaries who are now uncovered. And it is of great concern to me when I hear reports that the reimbursement schedules are deterring doctors from wanting to treat patients who are on Medicare and Medicaid.

You know, I believe we have got to watch that closely. And to cut the program at a time when you are not even making adequate reimbursements just seems crazy to me. Over the past 30 years, the Finance Committee has always been committed to the 35 million people beneficiaries which the program serves. I think we have to enhance that commitment, not just stay committed to it.

But let me just ask one question to all of you. Section 2003 of the President's bill gives the Secretary authority to exclude from coverage under Medicare part A drugs for which the Secretary has not been able to negotiate an acceptable price. Now this provision clearly gives the Secretary authority to deny new drugs to senior citizens because of their price.

The experience of countries such as Britain which operate under a global budget is that care is rationed to the elderly. Now, we know that the elderly have routinely been denied life-saving treatments and drugs in Britain. Can you give us your thoughts about how you see the impact of such an exclusion on the delivery of new drugs for the elderly? May we start just left to right?

Mr. CORRY. Senator, I think probably more has been said and written about that one section than any of the other provisions. It provides obviously a broad grant of authority to the Secretary. We believe that if there is—and we believe there should be—an outpatient pharmaceutical benefit, there has to be strong cost containment.

There will obviously have to be special attention paid to be sure that so-called breakthrough drugs, if they are really breakthrough drugs, can be brought onto the market, keeping in mind the investment that the pharmaceutical company may have made.

However, I want to recall, if you will, the experience that we had with the Medicare catastrophic drug benefit. As Senator Chafee, Senator Durenberger, and others remember who helped to try to fashion that benefit, in the end, in the conference report there was no cost containment. That was left for next year or the following year or the next reconciliation bill.

The lack of that cost containment drove the premiums through the roof. As I think both of you will recall, trying to find the last billion dollars to pay for that benefit drove that so-called surcharge or supplemental premium another $300 on the maximum.

So we would be very, very careful, obviously, to be sure that breakthrough drugs can indeed be brought onto the market because of the benefit that they would bring. But at the same time, we want to be sure there are strong cost containment provisions. We are talking, obviously, with a lot of pharmaceutical interest to try to see whether or not they have other ideas. But we would urge you to exercise real caution in this area to be sure that there is cost containment on any pharmaceutical benefit.

Senator HATCH. Dr. Duvall?

Dr. DUVALL. The AMA would share your concern, Senator, of having that much power centralized. With any new breakthrough drug there would be a strong scientific base to its development. I doubt if there would be great opposition for fair accountability of those development costs, which probably can be actuarialized and accounted for.

The savings that Senator Moynihan talked about in terms of the drugs used in treated acid peptic disease are a good example of savings that can accrue to the system through drug development. I think an even better example is the experience with mental health care needs with the major tranquilizers and other mood altering drugs. I mean, there are many savings that can be achieved.

I think one thing that we should be looking at more seriously as a more positive incentive is better research funding, probably through NIH mechanisms typically to help support the research and offset some of the costs of these new drugs under development.

Mr. DAVIDSON. Senator Hatch, I would put it in a different context and say that the last thing we want to get into is a regulatory

arrangement to regulate the infusion of technology and pharmaceuticals and all of the rest.

What we need to do is to reverse the incentives. These things need to come on line into the market place, into delivery systems that have fixed payment where we ultimately are very careful about the way we allocate our resources and there needs to be a lot of discretion in the use of new technology and new pharmaceuticals and there must be shared responsibility in organized delivery systems.

That is the best way to treat these matters as opposed to regulating them.

Mr. HALVORSON. Senator Hatch, I would agree very much with what Dick Davidson just said. We should be focusing on what works. We should be focusing on using drugs that improve outcomes. And when drugs do improve outcomes, we ought to be using them, and we ought to be using them in the context of teams of providers working to improve the overall output and outcomes of the system.

If we delegate that to some regulatory body, the likelihood is that that would be somewhat arbitrary, somewhat bureaucratic, somewhat inflexible. I have little confidence that it would be as effective as a marketplace approach would be.

Senator HATCH. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. Mr. Chairman, I am struck by some degree of irony here. In posing a question to Dick Davidson, with whom I had a very good talk two nights ago when I was in Pittsburgh, I would point out to him that the Lewin study is very much like the Nunn-Domenici amendment which we had on the floor the other day, which would have cut $99 billion out of Medicare willy-nilly. And then, of course, the purpose was to save that for Defense.

And to his great credit, John Chafee voted against it. He is, however, the only member of the Republican side of this committee who voted against that amendment. So when we are talking about cuts in Medicare, we have various ways of expressing our views on cuts in Medicare. That is typical of Senator Chafee and showed his courage. He was joined by Senator Jeffords in that.

And, of course, the amendment carried. As you know, the amendment won. Then Senator Mitchell was smart enough to be able to turn that into a sense of the Senate resolution, but otherwise it would have been binding by the Senate. That would be just devastating and I hope all of you gentlemen understand that when we talk about Medicare.

What the Lewin study basically demonstrates is a Nunn-Domenici amendment. And from the hospital point of view—and this has been mentioned already—PROPAC says that Medicare pays you at about 90 percent. You did not disagree with that when we talked in Pittsburgh.

Mr. DAVIDSON. Eighty-eight cents on the dollar.

Senator ROCKEFELLER. All right. So Medicaid, which is less, and PROPAC says it is about 80 percent, 80 cents on the dollar. Medicaid is going to disappear except for the long term part. That is all

going to be a part of the Clinton plan and paid at the same rate that others who are in the alliances will be paid. So that will be a big bonus for you, will it not?

No more Medicaid.

Mr. DAVIDSON. We would like to believe that that improved payment will be a big help.

Senator ROCKEFELLER. But if it passes it will be.

Mr. DAVIDSON. It will be improved——

Senator ROCKEFELLER. And that is not reflected in this study?

Mr. DAVIDSON. No, that is not.

Senator ROCKEFELLER. Universal coverage, of course, would end the inappropriate use, wasteful use, of emergency rooms and would mean that you would have the end of uncompensated care for hospitals; is that not correct?

Mr. DAVIDSON. We do not think that that is actually correct, Senator.

Senator ROCKEFELLER. How is that incorrect?

Mr. DAVIDSON. No matter what direction you go, there are always going to be people who fall outside of this.

Senator ROCKEFELLER. Yes, so there may be 1 or 2 percent.

Mr. DAVIDSON. I am talking about aliens and so forth.

Senator ROCKEFELLER. But instead of having 40 million you are going to have 3 or 4 million. Most everybody is going to have health insurance. Virtually everybody is going to have it.

Mr. DAVIDSON. But I would like to caution you that there is a difference between having coverage and having access. Last year, and this year as well, where the 90 million Americans will visit hospital emergency rooms, spend a day in the hospital——

Senator ROCKEFELLER. I do not want you telling stories. This is my 5 minutes.

Mr. DAVIDSON. All right.

The CHAIRMAN. Now you can have a little extra.

Mr. DAVIDSON. The point is that they will still come even with health insurance to hospital emergency rooms because they may not have access to a physician. That pattern is clear with many——

Senator ROCKEFELLER. Yes, but it is going to be a much diminished pattern, because what is going to happen over the next 6 or 7 years is that while we are implementing health care reform the American people are going to grow tremendously in their understanding of access, what they can do about health care, and also their own individual responsibilities. And emergency room use is going to go down, it is going to be used for what emergency rooms are meant to be used for.

You would agree with that, would you not?

Mr. DAVIDSON. But not for the Medicare population in that we are not seeking alternative ways to treat them.

Senator ROCKEFELLER. I have not gotten to Medicare yet. All right?

Mr. DAVIDSON. All right.

Senator ROCKEFELLER. But Medicare is outside that system?

Mr. DAVIDSON. Yes.

Senator ROCKEFELLER. But Medicaid is in the system and all of a sudden your reimbursements, therefore, go from 80 cents, let us

say, to 100 cents on the dollar or something of that sort. It would be, what, everybody else pays in the alliance.

You would also have the advantage of malpractice reform, which I hope will be stronger than what the President has. That would help you, would it not?

Mr. DAVIDSON. It certainly would help. But we need to realize that that will help in a limited way in terms of the actual fiscal impact.

Senator ROCKEFELLER. But every 1 percent, 2 percent of whatever counts, does it not?

Mr. DAVIDSON. Sure. One percent multiplied many times adds up to a big number.

Senator ROCKEFELLER. Right. And then there is also going to be clarification of anti-trust laws for hospitals and this is also true for doctors; is it not? In malpractice reform, will that not help you, Dr. Duvall?

Dr. DUVALL. I think it will probably help us more than the hospitals because it has to do with what we do.

Senator ROCKEFELLER. But it will help. Yes.

And for both of you anti-trust laws will be clarified so that you are able to negotiate, and collaborate when appropriate. Will that not be helpful?

Mr. DAVIDSON. That will be helpful.

Senator ROCKEFELLER. The standard benefit package will reduce your need to track insurers different coverage rules, will it not?

Mr. DAVIDSON. It should be helpful.

Senator ROCKEFELLER. Will not the single claim form, which will surely be part of health care reform, will that not enormously reduce the 1,500 different pieces of paper that you have to deal with?

Mr. DAVIDSON. If, in fact, you pass the President's plan, that would be a big help.

Senator ROCKEFELLER. And hospital costs for health insurance premiums for their own employees, in fact, will grow much more slowly than today. So that your 80 percent would, in fact, be cheaper than before because of the alliances and the efficiencies that are achieved through that. Premium contributions will be more equitable. Hospitals will no longer have to pay for health coverage for their workers' spouses; is that not true, if we pass the Clinton bill?

Mr. DAVIDSON. Yes.

Senator ROCKEFELLER. So that is a help. Health benefits administration costs will be dramatically reduced. I think we have already talked about that.

Well, I guess I would just ask one final question, in that I have not asked any. [Laughter.]

Mr. DAVIDSON. You have asked me some, Senator.

Senator ROCKEFELLER. We agreed that a trillion dollars is being spent on health care this year, 1994. We agreed that about $200 to $250 billion of that is inappropriately or unnecessarily wastefully or, in some cases, fraudulently spent. There is no disagreement on that, is there?

Mr. DAVIDSON. We will not debate it.

Senator ROCKEFELLER. Is there some part of that which belongs to hospitals?

Mr. DAVIDSON. Conceivably.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller. Did we all agree on $250 billion?

Dr. DUVALL. No, not me.

The CHAIRMAN. All right, as usual we are not——

Senator ROCKEFELLER. Mr. Chairman, I have to say it is a figure which I have found over the last number of years very few people disagree.

The CHAIRMAN. Well, we do not hear a lot of disagreement.

Senator ROCKEFELLER. Yes.

Mr. CORRY. Mr. Chairman, if I could perhaps take a moment to address Senator Rockefeller's comment. I think what you are hearing from this panel is not a lack of recognition that there will be additional reductions in Medicare, whether it is in health care reform or as part of the Entitlement Commission's recommendations which this committee might take up, or whatever the next floor amendment might be.

I do not think that anyone here seriously suggests that there will be no further Medicare reductions in the future. I think what we are saying, however, is that the careful stewardship which this committee has exercised needs to continue to protect the program's integrity over the years, that that integrity is showing signs of stress, not only in rural areas, but also in urban areas; not only for providers, but also in terms of access and growing costs for beneficiaries.

When the committee has acted as a part of budget reconciliation over the years, we all know for a fact this committee has tried to make the best of a bad situation at times. In the case of health care reform, I think we see the opportunity that these savings will be no less challenging but can help move forward a comprehensive bill.

The CHAIRMAN. Thank you, sir. Can I just go back to Mr. Davidson's point that a quarter of all hospitals have negative total margins. Is that not what you said?

Mr. DAVIDSON. Yes, sir.

The CHAIRMAN. Which is to say that total payments from all sources are less than total costs. Well, that is not something that can continue indefinitely and we have to address that, and Mr. Halvorson agrees. I am interrupting.

Senator Daschle?

Mr. DAVIDSON. Mr. Chairman?

The CHAIRMAN. Sir.

Mr. DAVIDSON. May I make a comment?

The CHAIRMAN. Please, sir.

Mr. DAVIDSON. The Senator's questions are very significant, if, in fact, you were to enact the President's plan in terms of what other changes may take place. The only point of our entire study was to give you a sense of the magnitude, even if there is a 20 percent margin of error in our research, give you 20 percent. You will still see those numbers being dramatic and the only point is that there is fragility in this system.

And as we move forward toward reform, you want to be certain that you do not dislocate the very institutions that you expect to provide access to those people who will have expanded access. That

is our entire point. We are for tough choices and we will work with you on that.

The CHAIRMAN. I am sure Senator Rockefeller agrees.

Senator ROCKEFELLER. I have no argument with that.

The CHAIRMAN. You have no argument whatever. Good.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

My concern is that we have not sufficiently used this opportunity to explore what the witnesses would do if they were in our position.

Each of you has heard the ominous predictions of how Medicare will impact the budget in future years. You have heard Leon Panetta and countless others describe in vivid detail how health care spending will have extraordinary implications for the Federal budget if we do little or nothing.

It is projected that if we do little or nothing, costs in Medicare will rise at least 11 percent over each of the next 5 years. That would mean at the end of 5 years Medicare costs will be 50 percent greater than they are today.

Last year you vehemently opposed a proposed cap of 4.7 percent on entitlement increases. You have now indicated concern about the President's proposed 2.3 percent cut in the rate of expenditure increase which would still allow Medicare expenditures to grow more than double the rate of inflation over the course of the next 5 years.

Put yourself in our shoes. Let me just stop here and ask, would you all agree that 11 percent is too high?

The CHAIRMAN. Can I ask, is the question ought you to have 11 percent or will you have 11 percent?

Mr. DAVIDSON. Senator, you cannot look at the number in isolation. It was just last year, OBRA–93. We cut $56 billion out of the Medicare program. Three years before that, OBRA–90 you cut $43 billion out of the Medicare program.

Senator DASCHLE. Mr. Davidson, that is not what I am asking. We are being told that we can expect growth in the program to equal or exceed 11 percent roughly each of the next 5 years. What I am asking is whether there is at least general agreement that that 11-percent increase on an annual basis for Medicare is too high.

Mr. DAVIDSON. I think it is a reflection of a prediction of the demographics of the Medicare population and the traditional patterns that we have used to take care of people. And we have to change the patterns and develop new incentives.

Senator DASCHLE. But that is not what I am asking, and we will get to that. But would you agree that 11 percent is too high?

Mr. DAVIDSON. I think 11 percent is an accurate reflection of what real costs will be under the current system.

Senator DASCHLE. And we should accept that? Is that what you are telling me?

Mr. DAVIDSON. No, we are saying—no, we are recommending that you change and provide——

Senator DASCHLE. So it is too high.

Mr. DAVIDSON [continuing]. New incentives for the delivery of care to Medicaid patients.

Senator DASCHLE. Mr. Corry?

Mr. CORRY. Sir, I think what we are saying to you and what we have said consistently is to focus only on Medicare will not work.

Senator DASCHLE. But who is suggesting that that is all we do?

Mr. CORRY. I am not sure that all of the—as I say, I do not want to speak for those here. I am not sure that everyone here would ascribe to that. We are saying that you need system wide cost containment provisions, whether it is the President's plan or someone else's plan that you wish to look to.

If you look at what is happening in the Medicare program's rates of increase versus the private sector, Medicare's per enrollee costs have been lower than in the private sector. If you look over on the tax side of the ledger, the growth in health tax expenditures, particularly on the employer deduction, is as fast if not faster than the Medicare program.

So what we are suggesting to you is, rather than only look at Medicare and Medicaid, which promotes more cost shifting to the private sector, you look at the whole system and solve Medicare's problem when you solve the rest of the system.

Senator DASCHLE. Well, I think that is not even contested. Everyone understands the need for some comprehensive systemwide solution to the problem of spiraling health care costs. But if we are to judge our success in containing costs, surely we must look at the rate of growth in program costs during the out years.

You have indicated generally that 11 percent might be too high for a lot of good reasons. You have also indicated to us that the President's proposed limit of around 8.7 percent may be unacceptable. I guess my question is, what would be a reasonable target that you would suggest to us if those figures are unacceptable and how would you get there?

Dr. DUVALL. I think it is dangerous to pick a number like that. That is why the AMA is against global budgets or predetermined caps like you all discussed the other day.

Senator DASCHLE. But then how do you judge success, Dr. Duvall?

Dr. DUVALL. Well, you are going to still have the numbers and there still can be a process of good faith negotiation between the stakeholders in working with those numbers. There are so many variables and complexities. I mean, who would have predicted an AIDS epidemic 10 years ago? Who would have predicted the antacid drug success?

I think we would have to work to get as much fat out of the system as possible using outcomes analysis and better research and more competitiveness. But I think to pick a single number and somehow decree it as chipped in stone is fallacious at the outset.

Senator DASCHLE. Well, no one is suggesting that we pick a number and lock it into concrete. But I am saying we have to use some measure by which to judge our success. All I am asking is your guidance on how we do that.

Mr. Davidson?

Mr. DAVIDSON. In our reform recommendations, in terms of our vision of the future, we believe there needs to be an independent national commission that has oversight of the determinations of resource allocation for health care and that it is fair to say that this Commission should establish a definition of benefits to be in any

national standard benefit package and ultimately provide to you a budget mark that can provide a given set of benefits and have you vote them up or down.

We believe that this Commission ought to be the one that ultimately determines capitated rates because it does a lot of research and focuses on this and then gives you a set of recommendations, and that this Commission be the one to determine whether, in fact, that 11 percent number is accurate.

In the absence of effective oversight and full, broad examination of this in the light of day, it is hard to make these determinations. We think there ought to be a body that gives sunshine to all of these issues. And we ought to consider the question of whether we have targets and goals in terms of national expenditures and that we talk about them, and we monitor behavior and we look at new disease categories, and in some years we may come in under a goal or a target and in other years we might exceed them, but we would understand why.

Today we do not have an ability to answer that. So we would start with that notion first and then after that we would say that you have to bring about reform in the way health care is delivered for all Americans. You cannot isolate the Medicare population from changing the way we deliver care. And virtually all of the proposals that are being looked at isolate Medicare. They must be integrated in order to make these things happen. That is essential to behavior change.

The CHAIRMAN. I think Mr. Halvorson had wanted to comment.

Mr. HALVORSON. If I could make two very brief comments. One is that you might find it very useful to look at the cost of Medicare on a per capita basis and not on a total program basis, because otherwise you are bringing too many issues to bear. And it is difficult to identify whether or not any cost containment is taking place without that per capita cost factor brought in.

The second point is, it is almost impossible to achieve any kind of efficiency in a nonsystem where providers do not work in teams toward common goals and continue to be separate business units, each reimbursed for volume. It is almost impossible to make the system efficient.

Therefore, 11 percent is probably a pretty good predictor. It is not a great goal, but it is a good predictor.

Senator DASCHLE. Thank you.

The CHAIRMAN. Well, there was a cold north wind. You are used to those. [Laughter.]

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman. Well, before I start with that maybe I could say for the benefit of the record and my colleagues, as we were talking about rural hospitals I did a little checking in our State. Fully 20 percent of the hospitals in North Dakota are operating at a loss—10 of the 50 hospitals are operating at a loss.

The 35 smallest hospitals, those below $5 million of receipts, are all on average operating on negative margins. The next 6, the medium-sized hospitals, had total margins of plus 5 percent; the 8 largest, plus 3.4 percent.

So when we look at the Medicare cuts that are proposed or reductions of increases more accurately than cuts, reductions in increases that are proposed, that is a sobering thought when you have 10 of your smallest hospitals already operating on negative margins. Fully 20 percent of the hospitals in my State currently operating under negative margins and I would venture to guess every one of them has a disproportionate share of Medicare-eligible patients.

Some have suggested to me, well, we are going to have a greater percentage of people covered and that is going to offset the Medicare reductions. The problem with that is, 91 percent of the people in my State are already covered. It is very hard to see how the math works out.

Frankly, I think those hospitals that have a disproportionate share of Medicare-eligible patients, that already are flowing red ink, would be out of business. That is 20 percent of the hospitals in my State.

Mr. Chairman, when we get down to the final determination this is going to be very much on my mind in any plan.

The CHAIRMAN. Of course it will be.

Senator CONRAD. In how it deals with those special situations of a rural State.

Mr. Davidson, you referred to the Lewin study. And Senator Rockefeller I think quite properly went through all of the defects of that study, things that are left out.

Let me ask you this in a subjective way. Knowing what you know about the operations of hospitals around the country, even with these other factors put into the equation that Senator Rockefeller went through, is it your judgment that rural hospitals with a disproportionate share of Medicare-eligible patients under any of the plans that suggest significant savings in Medicare would have their survival threatened?

Mr. DAVIDSON. Senator, I think it is fair to say, and I think we all need to understand, that whatever direction we go in, not all hospitals will survive and perhaps not all should. It means we are talking about a major reconfiguration of the hospital field in America. And the test is, what is the way to reconfigure the field. Is it this starvation diet strategy or is it a strategy that provides incentives for people to come together in communities, perhaps throughout your State, and make some determinations as to where the essential players need to be.

The American Hospital Association will not recommend to you that you have a payment system to keep all ships afloat. We will not do that. The reality is that all ships are not going to stay afloat and the issue is the mechanism by which we make the determination. That is what we are talking about here.

The current payment system is not the way to do it. It has the wrong incentives. And just starving everybody is going to damage your institutions and maybe the wrong ones. We have to have a different mechanism to do this. That is what we are advocating.

Senator CONRAD. Let me ask you, if I can followup, and then I want to go to Mr. Halvorson. Do you think something like EACH-PCH can help with that reconfiguration?

Mr. DAVIDSON. Yes, sir.

Senator CONRAD. You are supportive of that approach?

Mr. DAVIDSON. Yes, sir.

Senator CONRAD. Mr. Halvorson, you talked about HMOs. Every time I talk about HMOs to people at home I get two reactions. Number one, lack of choice. All of a sudden you are going to be caught up in a system in which you cannot chose your doctor. You are going to go to somebody else that is going to be a gatekeeper and they are going to determine who you see.

And if they do not think you should see a certain specialist, you are not going to see that specialist. What is your response to that?

Mr. HALVORSON. My response is that all of the people in our health plan are there by choice. They chose us as their doctor when they chose the health plan, number one.

Number two, within the health plan, our members can chose a different doctor at any time, and people are not locked into a doctor. One of the myths about HMOs is that you are assigned a doctor or given a doctor or you go to a particular doctor and cannot change. That is absolutely a myth. People can change physicians all the time.

The third point is that, just taking our health plan, for example, I think we have more physicians in our health plan than the States of Montana and Wyoming combined. I think we have more than adequate choice within the health plan of physicians, and we have very carefully chosen the physicians to begin with, based on their credentials and their quality and their ability to do the job.

So, we typically do not have a choice problem. There is a myth that there is a limitation on choice within the plans, but that is not true. The other issue relative to that, is in North Dakota you are blessed with two wonderful large multispecialty group practices—Fargo Clinic and Dakota Clinic—who are very likely the core of any kind of HMO.

Once people have chosen between those two organizations, they would be given a free choice inside of those organizations, which would be as good or better than anything they have right now.

Senator CONRAD. Mr. Chairman, might I ask one final question?

The CHAIRMAN. Would you please?

Senator CONRAD. The other thing that I hear about HMOs is the fear of many that incentives will change from doing too many tests and too many procedures to too few. That is, when you move from a fee-for-service plan that has the incentive, all the incentives flow toward doing more tests, more procedures.

When you go to an HMO format, a capitated amount for each member of the group, is there not an incentive to do too few procedures, too few tests, provide too little service?

Mr. HALVORSON. In the early days of HMO organization, the only HMO models that existed were the staff model plans where the physicians were on salary. And in that model there is absolutely no financial incentive for the physician to deny any services or to not do anything relative to any given patient.

As HMOs evolved, there was a brief period when capitation was probably not done as well as it could have been. I think there were some stories that came out of that time frame.

Overall though, HMOs do not incent physicians individually not to provide care. The marketplace demands quality. The consumers

demand quality. What we have been urging, and Senator Durenberger's bill provides for, is national measurements of quality.

In fact, HMOs have taken the lead, through the HEDIS program, in establishing the first uniform measurements of quality across the board because we want consumers to have absolute peace of mind, that when they purchase care, they are getting care of measurable high quality.

And, if we were going to design a perfect health care delivery system for the future, it would be a delivery system in which consumers could pick between teams of providers based on the measurable quality of care and on the known satisfaction within those programs, so that we can really empower consumers to make choices, and we can reward the system for quality. So I would not consider that to be a major issue.

Senator CONRAD. Thank you.

The CHAIRMAN. Thank you, indeed, Senator Conrad.

Could I just make a point? We earlier talked about the question of breakthrough drugs and I think that it should be recorded that in the President's bill the Secretary shall appoint an Advisory Council on breakthrough drugs that will examine the reasonableness of launch prices of new drugs that represent a breakthrough or significant advance over existing therapies.

I do not think those are terms that would suggest any methodological rigor. What is a breakthrough? Do you know a breakthrough drug when you see one, Dr. Duvall? Does it come through and you say I have a breakthrough drug and I have just an ordinary everyday drug?

Dr. DUVALL. It would be hard to. Well, you can tell from the science though.

The CHAIRMAN. The JAMA will tell you something large has happened in the clinical tests and such.

Dr. DUVALL. I know it would have to have a scientific rigor that substantiated the excitement.

The CHAIRMAN. Yes, it worries me as a term. It is a military term or a football term. I do not know what. But it is not a medical term.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. Oh, yes, when the sons of Eli break through the lines. Is that not what happens? Here is this other line.

Senator CHAFEE. Our team shall never fail. Bull dog, bull dog, bow-wow-wow. Eli Yale. [Laughter.]

Now I am extremely interested in the efficacy of HMOs and it just seems to me as you have outlined it, and with other information that has been available that their ability is extraordinary. And what I think is one of the prime rationales in favor of HMOs is their effort to keep people well, keep people healthy, as Mr. Halvorson said. Keep them from getting sick.

From your testimony, Mr. Halvorson, you indicated that 20 percent of all insureds in our Nation now are in HMOs. You and I discussed this last Wednesday, Mr. Chairman.

The CHAIRMAN. Yes.

Senator CHAFEE. I think I said it was 40 percent and I was off. It is 20 percent. I would have thought it was higher. But on the

other hand, of the Medicare beneficiaries only 4 percent are in HMOs.

Mr. HALVORSON. That is right.

Senator CHAFEE. Now, what is the matter here? As I understand it, under the so-called—everything has a name in this business—TEFRA risk contract—that the Medicare beneficiaries that are in HMOs, the HMO is only reimbursed at 95 percent of the average within the area.

I presume that is a disincentive to start with. Is that right, Mr. Halvorson?

Mr. HALVORSON. Yes.

Senator CHAFEE. In our State an HMO that tried to take care of the Medicare beneficiaries and indeed provided prescription drugs under this so-called TEFRA risk contract went broke, could not do it. What has been, one, your experience; and, two, would somebody tell me, if they know, what is the rationale for only paying 95 percent? Why not pay 100 percent?

Mr. HALVORSON. Senator, you make a couple of very good points. One of them is that the TEFRA program does reimburse at 95 percent. That 95 percent is a calculation that supposedly is based on the area cost of fee-for-service. The truth is, those numbers are, as Senator Durenberger pointed out earlier, extremely inconsistent numbers.

You can cross a county line and see a reimbursement drop in one foot by $50 or $100 a month per senior for no discernible reason. We do not know information about the rates until very late in the year, typically November/December. When we find out the information, we do not know if the rates are going to go up or going to go down.

So one of the major reasons that only 4 percent of the Medicare population is in an HMO is that most HMOs have just said, "this is not a good program for us." There is no point in participating. The vast majority——

Senator CHAFEE. Now let me ask you as an HMO representative and representing not only your company but the industry, suppose we reimburse it 100 percent. Would that make any difference?

Mr. HALVORSON. I suspect that would make a difference. I also think 100 percent of what? I mean, one of the issues is that there is still a tremendous geographic inconsistency county to county that is a problem. This applies to fee-for-service Medicare as well.

I saw a situation in our State where a hospital basically moved itself across a county line to get into a different reimbursement level, to get into a metro reimbursement level versus a rural reimbursement level. There are some very inappropriate ways of computing the average area per capita cost. But, yes, 100 percent would be much better than 95 percent.

The CHAIRMAN. I bet you would say that.

Mr. HALVORSON. I would say that, yes. [Laughter.]

Senator CHAFEE. Well, I suspected he would say that also. But the question is, would it make any significant difference.

Mr. HALVORSON. I think it would make a difference in a great number of cases that are marginal, yes.

Senator CHAFEE. What do you say, Mr. Corry, to that approach? In other words, I know in certain parts of the country if the Medi-

care beneficiaries enroll in the plans, for example, they get prescription drugs. And thus in the southwest anyway, there is a substantial number of Medicare beneficiaries that join those plans.

Mr. HALVORSON. Right.

Senator CHAFEE. Now that is what you call a three-for. The individual wins; the plan makes money; and the U.S. Government saves money.

Mr. CORRY. Hopefully.

Senator CHAFEE. But that cannot be apparently duplicated. At least it was not duplicated in my section of the country.

Mr. CORRY. We have been very supportive of HMOs and managed care generally over the years. As a choice, as an option for our members, where it is available and where it is good quality. We have members who are enrolled in HMOs—for example, some of Senator Durenberger's constituents are real cheerleaders for this kind of care because it does provide them with something that they cannot get elsewhere, but also because they chose to do that.

I think the short answer to your question about how the 95 percent, goes back to the original Stockman—Gephardt legislation back in the late 1970's and early 1980's and the history of which is probably more checkered than you can cover right now.

But we have always been concerned that our members have that option. It is true that in many cases that is the only way they can get prescription drug coverage. There is a difficult hurdle, if you will, though for many older persons in exercising that option over and above the issues of payment to the provider. That is, they have a physician perhaps of many years.

We often find that when someone who is older chooses to go into an HMO it is either because their physician has migrated over or their physician has retired and they are in the market, if you will, for a new physician. We expect that is going to be somewhat different for our younger members.

The 40 percent figure you used, Senator, I think is roughly the proportion of those in the labor force who are in some kind of managed care. We expect that many individuals will stay in that.

Senator CHAFEE. You mean that the figure was distorted because of insured to include Medicare?

Mr. CORRY. I do not know where the figure came from, but my recollection is that 40 percent of the working population.

Senator CHAFEE. Mr. Halvorson, you gave us the figure of 20 percent of the insured are in——

Mr. HALVORSON. In HMOs.

Senator CHAFEE. Is that when you include 20 percent of what—20 percent of a group that includes Medicare beneficiaries?

Mr. HALVORSON. Of the total insured population.

Senator CHAFEE. Which means Medicare and Medicaid?

Mr. HALVORSON. I think it does, yes. I think the difference between the 20 percent and the 40 percent is that the 40 percent probably includes the preferred provider organizations. So it is closed-panel managed care, but it is not HMOs.

Senator CHAFEE. All right. I am sorry to interrupt you, Mr. Corry.

Mr. CORRY. In any case, we expect that as more of our members, and half of our members are under age 65, have the experience, if

it is a good experience, in some kind of managed care system, whether it is a formal closed panel HMO or otherwise, that they may well choose to remain in that if they can.

Currently though there is a real hurdle for them to do that. So this is something that for someone who is 75 or 80 may be a very daunting issue. But for someone who is 55 or 60 looking at Medicare eligibility 5 or 10 years out, it may be the natural thing to do.

Senator CHAFEE. Well, Mr. Chairman, I just hope that in our deliberations here in deciding what to do in these various problems that we always bear in mind that we follow a course that there are incentives for the people to stay well and there are incentives for those providing services to keep the people well.

Maybe fee-for-service does that. But clearly in an HMO that is true. Now I do not know what my time is here.

The CHAIRMAN. You have all the time you wish, sir.

Senator CHAFEE. Doctor, am I a cynic to think that there is a greater incentive in a managed care plan to keep people healthy than in a fee-for-service arrangement?

Dr. DUVALL. I do not think there is a greater incentive. I think it is more clearly and programmatically seen. But, you know, private doctors characteristically have been doing all the things that were talked about at the end of the table. Maybe that is why so many Medicare beneficiaries continue to choose fee-for-service. We try to keep people well. It is actually not a covered service, such as screening for cancers in the older population without symptoms, except every other year mammograms and now pap smears. I mean that this limited coverage has just been a recent thing.

We are doing it all the time and we are doing it under what you would call a counseling part of the code, which is not covered or paid for. We can do more and we can improve our ability to do that.

I would like to insert one other thing in terms of choice, which I think is terribly important. It was described how patients choose us as part of a plan and after that they have pre-choice. I understand what you are saying.

That represents an entirely different way for the American patient to be thinking. Normally they choose a doctor. So that is a slightly different choice than most people generally make. There is no reason with modern technology that that freedom and that ability to make a choice cannot be preserved.

Even in Senator Durenberger's bill, which we have not had a chance to study yet, that choice is out there like in the Federal program here in town. We would commend that, but it can be made and preserved even on an episode of illness basis without any real difficulty.

We talked about the HEDIS 2.0 study and quality report cards. These are all things you need as you search for value in health care dollars and you cut the price right down to the very bone itself. You need to know when not to make that last cut before you have cut actually into quality.

So keeping the fee-for-service option available is the way to recognize that Americans walk with their feet: if they do not like the quality they will tell you by going somewhere else.

Senator CHAFEE. Just one quick question to see if I understand it. It was said here that—I guess by Mr. Davidson—a very substan-

tial number of our hospitals are running in what we call negative margins. That is a euphemism for at a loss, is it not?

Mr. DAVIDSON. Yes, sir.

Senator CHAFEE. Now, where I come from you cannot run at a loss very long, except apparently the Federal Government. What is the difference? Do they make it up with endowment income or charitable contributions or what?

Mr. DAVIDSON. The institutions that I cite to you, Senator, are ones that at the end of the year have taken in less money than they spent in taking care of patients. That may already include endowments to offset some of those numbers so that they are actual net margins that I am talking about. You can only run a system like that so long.

It is like anyone's household budget, or a business or anything else, there is a point when you cannot ultimately in the most serious case meet a payroll. That is what these institutions can be up to if, in fact, we go down the path as we have talked about in our study.

I would like to just make one note, because I think it is very important because some questions have been raised about the study and what it is that we have shown you. The study was done in isolation because the Medicare plan is not in the President's proposal.

And second, there is no intent of the President's proposal to take any savings to expand access to other Americans. So we did our methodology—and I would have wanted Senator Rockefeller to hear this—we did our methodology just as it has been proposed. The Medicare program is isolated from the rest of the reform plan in the President's proposal and it does not bode well for those institutions that have these tough margins.

Now, we call for changing the way things are delivered and over time we will get there. But you may lose a lot of critical providers before you ever get to where you want to get to.

Senator CHAFEE. Thank you, Mr. Chairman. I just would point out finally that the points that Senator Rockefeller ticked off—the administration reform, the anti-trust reform—all of those are included in the bill that I and others submitted.

Second, we provide prescription drugs in our legislation. That would be part of the uniform benefit package for those Medicare beneficiaries who chose to come into our system. There would be prescription drugs available for them.

Thank you very much.

The CHAIRMAN. Thank you, Senator Chafee.

Senator CONRAD. Mr. Chairman?

The CHAIRMAN. Please, Senator Conrad.

Senator CONRAD. Might I ask a last question of Mr. Davidson.

The CHAIRMAN. It sounds like we are going to put him up against the wall or something. [Laughter.]

You can ask a further question by all means.

Senator CONRAD. Thank you, Mr. Chairman. I will not put him up against the wall at this time.

Mr. DAVIDSON. Thank you, Senator.

Senator CONRAD. He has had a tough enough day here. The reason I wanted to ask a last question is, I thought it would be a mis-

take for us to conclude this panel without talking about the research hospitals and the teaching hospitals specifically.

I have just the last week have met with the University of North Dakota officials. We have a medical school that works through hospitals in the State. The week before I had met with the Dean of the Stanford Medical School.

I am getting a consistent message that we have to be especially sensitive for the research and teaching hospitals because we have basically through a back door developed a system to take care of their special needs. That is, the costs of running these research facilities, the teaching hospitals, is higher than other facilities.

We have found arrangements by which we take care of the problem. Now there is great concern in health care reform that those special provisions will be lost and that these great institutions that are providing a significant service in the country will fail, will financially fail.

And, Mr. Davidson, I wonder if you would comment on that question and alert the committee as to how we deal with this question.

Mr. DAVIDSON. Well, currently teaching and academic medical centers derive a lot of their income through rates paid through Medicare and other payers that offset direct and indirect medical education costs. We are aware that that is how we have decided to, in fact, fund medical education and research.

So that every time you seek to change the way you pay for care you have the potential of damaging the equilibrium in those institutions. And it seems to me it is a fair question to raise the public policy issue of is there an alternative way to carve those costs out of those institutions and find a different way to flow the funds.

One of the options is to create a national pool with redistribution of that money back to those institutions so that their regular rates can permit them to be competitive with other institutions in the community.

It seems to me there are other options that we can look at and we would be very pleased to work with you, Senator, and members of this committee in looking at those options in cooperation with the Association of American Medical Colleges.

Senator CONRAD. I just would conclude by saying it is very important that we do that because clearly their rates are higher than others with whom they would be expected to compete.

The CHAIRMAN. Can I then say that the President has given me a very personal mandate that we attend to this question. Dr. Davidson said that, speaking of hospitals who have negative total margins, the New York City hospitals are just hugely the case. Those are hospitals that go back a long way and have seen endowments built up over two centuries dissolve.

I mean, the College of Physicians and Surgeons at Columbia was chartered by George II and relates to the time when physicians looked at you but did not touch you; and surgeons were the ones who did all the bloody work. And on balance, everyone was worse off when it was all over.

But you cannot be involved as we have in the last year in these hearings without having a sense that we are in a heroic age of medicine. After all these years, since about 1930—I see Mr.

Halvorson agreeing, Dr. Duvall probably does—medicine finally can do wondrous things.

And this whole question of preventative care takes on a wholly new dimension in the context of the developments in genetics. We can know about people who are going to have diabetic troubles, which no doctor would have known 50 years ago. When you got a disease you went to the doctor because you were sick and he tried to figure out what you were sick of and tried not to hurt you in the form of helping it to cure itself.

But keeping that intense dynamism is so important and avoiding rules made from Washington. Part of our Medicare problem surely is that we have tried, I am sorry to say, to micro manage. John Chafee, who is not present at the moment, will describe sitting down with Pete Stark in a room off the House Chamber at 3:00 in the morning and deciding how much we will charge for heart bypasses.

And even in the best of worlds they do not know and cannot. I have learned that Dr. Kessler of the Food and Drug Administration said there is no statutory or regulatory definition of breakthrough drugs. Do not act like we know, that we can tell you what a breakthrough drug is.

And we do have problems with preserving the creativity in the system. I wonder if I could ask Mr. Halvorson something I have heard but do not know at any level, which is to say that the University of Minnesota Medical School is having difficulties. Is that my understanding? Just that as medical care has become less demand driven and more cost conscious the medical school is finding itself in some troubles.

Mr. HALVORSON. Senator, that is absolutely accurate. The University of Minnesota has not maintained its traditional referral base or referral volumes and is looking at some creative ways of getting more actively involved in managed care to play a slightly different role.

But the future they see for themselves, if everything projects forward, straight line, is not a good one.

The CHAIRMAN. Is not a good one. Now here you are, I think this is a hugely important point. Take Minnesota, you have the most advanced health care systems. You have the largest coverage I think of anybody, perhaps North Dakota is slightly better, but you are neighbors. I mean, everything is what we would hope it to be and you look up and say, but our medical school is not in good condition.

That is an irony which we want to be attentive to. I am sure you would all agree. There are extra costs associated with this heroic age of discovery. We do not want to put an end to that because we are rationalizing other aspects of the system. Would you not agree?

Mr. HALVORSON. Mr. Chairman, if I could speak just to the Minnesota situation. One of the things that we as a health plan have done is merged with a teaching hospital, brought it into our system, and we are taking on some of the accountability for some of the residency programs because we know that there has to be a medical education program.

The CHAIRMAN. Not just education research.

Mr. HALVORSON. Right.

The CHAIRMAN. No. A cautionary tale.

Senator Durenberger, would you like to have the last word?

Oh, and may I say that this Thursday our hearing will be devoted to academic health centers.

Senator DURENBERGER. Mr. Chairman, thank you. I will not try to follow up on the comments relative to medical education or the University of Minnesota Hospital. I think we will probably get into that on Thursday. But between now and then and then during the rest of the week we are going to be reminded of an issue that was raised here when Dr. Reischauer was testifying on CBO. That is the inability of the Congressional Budget Office to estimate the expenditure consequences of behavior change.

We have talked for the last three hours about behavior change and the need for behavior change and everyone here has agreed on its necessity. We have listened to examples of parts of this country in which behavior change have produced results in expenditure, in diminished expenditures without diminishing quality or at least presumptively.

But we will get in a couple of days one of the first estimates of the so-called Managed Competition Act, which will show that it costs huge bundles of money. And then a week or two after that we will get estimates on the Chafee bill, which is going to say it is going to cost huge bundles of money.

The defect, as I understand it, in the Congressional Budget Office approach is that they insist on nationwide cumulative evidence of behavior change. They are unwilling to go into a market like Minnesota, go into a market like the Bay Area of California, go into the Albany situation, whatever may be going on in Albany that results in a $341 payment, and say this kind of behavior change results in the following expenditure consequences.

And if, in fact, the stimulus for that behavior is incorporated into the rules that are in the Clinton bill, the Chafee bill, the Breaux-Durenberger bill and so forth, then we might have national results over a five-year period of time showing us the following consequences.

I did not raise this, Mr. Chairman, to debate with Reischauer or CBO. We will carry on that debate in other areas, but it will always come back here. And so your offer six weeks ago just to convene a meeting of some kind at some point with estimators I think is going to be very, very critical.

The tough part in this getting health care reform passed this year is going to be to decide how do we get the universal coverage for the guarantee.

The CHAIRMAN. Right.

Senator DURENBERGER. And that means we are going to have to have some of these estimators sitting down with us and determining one way or another. Out there in the future we are going to have to look differently at the national process for estimating the consequences of everything we have heard here today.

I want to make sure that the Medicare population has the same chance as everybody else in America to benefit from this behavior change. They will not get it from more cuts. They will not get it from all of the rest of the recommendations on cutting the growth and the expenditure. They will only get it as everyone of these wit-

nesses said, from changing the way we deliver and the way they buy and they need to be given those opportunities.

They will not be given those opportunities if we stick with the way the CBO currently makes its estimating.

The CHAIRMAN. I think, Senator Durenberger, that is exactly the note to close on. We are going to have to make a judgment about the estimators. Because universal health care is our goal and we are going to get to it in this Congress.

But I can solve one question, which is, why are costs so low in Albany. I cannot absolutely solve it, but I can tell you that our two youngest children were born in Albany, as usual, in the winter. This was back in the 1950's in the old days of the organization there, and it would snow and snow. Minnesota has nothing on the snow in Albany, and nothing was ever done about it. And when asked why, the local alderman explained that the man who put it there takes it away. And enormous costs are saved just by waiting until April. [Laughter.]

And on that note, we will never know. Thank you very much for an extraordinary, helpful panel.

[Whereupon, at 12:27 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF MARTIN CORRY

Good morning. My name is Martin Corry. I am Director of Federal Affairs for the American Association of Retired Persons (AARP). Thank you, Mr. Chairman, for the opportunity to testify today on the future of the Medicare program under health care reform.

AMERICA NEEDS MEANINGFUL HEALTH CARE REFORM IN 1994

Reflecting the clearly expressed wishes and concerns of our members, AARP supports health care reform that provides *every* American

- quality health care coverage, not merely as a goal, but on a timetable specified in law;
- a long-term care benefit that guarantees security and peace of mind to Americans of all ages who are faced with severe disabilities and chronic illnesses;
- prescription drug coverage to assure that no American is denied access to essential, often life-saving drug therapies;
- system-wide cost-containment that assures consumers affordability, and doctors and hospitals a fair price; and
- financing that is fair and adequate.

AARP commends the members of Congress in both parties who have introduced proposals that would achieve universal coverage. We are particularly pleased that the President and co-sponsors of the Health Security Act, S. 1757, have included the following critical provisions:

- a home and community-based long-term care benefit for disabled persons of all ages;
- coverage of prescription drugs on similar terms for Medicare beneficiaries as for all other Americans; and,
- protections for non-working older Americans not yet eligible for Medicare.

HEALTH CARE REFORM MUST STRENGTHEN MEDICARE

AARP believes that pursuit of a better health care system for all Americans should include strengthening Medicare. For 35 million older and disabled Americans, Medicare provides an important level of affordable health security, and it is enormously successful and popular across all age groups. Rather than tear down the Medicare program through unrealistic program cuts or large-scale restructuring, health care reform must build on Medicare's successes and fill the gaps in benefits and low-income protections. Medicare can and should be maintained and strengthened as part of health care reform.

AARP believes that Medicare will continue to play a significant role in a reformed health care system, and that Congress should take care not to erode further Medicare's promise of limited health security. In fact, Medicare beneficiaries are in great need of important benefits such as prescription drugs, preventive care, and out-of-pocket limitations that are not part of Medicare today. And, all Americans need protection against the devastating costs of long-term care.

Clearly these benefit expansions will require additional financing, and AARP has always been willing to help identify funding sources and educate our members about the trade-offs involved. AARP believes that Medicare savings should be a part of this funding, but only in the context of system-wide cost containment and in a way that does not harm beneficiary access to care.

WHAT'S GOOD ABOUT MEDICARE

Medicare is the cornerstone of health care coverage for older Americans. Since its inception, Medicare has dramatically increased access to health care for those age 65 and over and the disabled by guaranteeing coverage regardless of health status and by attempting to keep costs for Medicare-covered services affordable.

Beneficiaries can choose where and from whom to receive care—from physicians or certain non-physician providers, through a standard fee-for-service or managed care setting.

Medicare also seeks to guarantee the quality of care through an external system of peer review and quality standards. Peer Review Organizations (PROs) independently monitor care, investigate beneficiary complaints, and review hospital discharge decisions.

While rising health care costs are a problem throughout the health care system Medicare has established important mechanisms that have consistently reduced the program's anticipated growth rate. Over the past decade Medicare has used innovative strategies to control program costs. Medicare's prospective payment system has significantly reduced the volume and price of hospital care. Similarly, following implementation of Medicare physician payment reform, physician volume growth dropped dramatically. In fact, since introducing cost containment measures, Medicare has been more successful than the rest of the health care system at controlling costs—one reason why some private insurers are now adopting Medicare's payment methods. The Congressional Budget Office recently found that between 1975 and 1990 annual growth in Medicare costs per enrollee was consistently less than the growth in private insurance costs per enrollee (Chart I).

Medicare's low administrative costs—about 2 percent of program outlays in 1992—help maintain its reputation as one of the most efficient federal programs. By contrast, administrative costs of private health insurance range from 5.5 percent to 40 percent of benefit costs.

MAJOR GAPS IN THE MEDICARE PROGRAM

While Medicare guarantees that virtually no one 65 or older is uninsured, there remain substantial gaps in coverage, inadequate protections against high out-of-pocket costs, and access problems. Major gaps in Medicare include:

- no long-term care coverage;
- no outpatient prescription drug coverage;
- Minimal preventive benefits;
- inadequate low-income protections; and
- no out-of-pocket limits.

THE STABILITY OF MEDICARE—COST CONTAINMENT, MEDICARE SAVINGS, AND FINANCING REFORM

AARP commends President Clinton and co-sponsors of S. 1757 for their willingness to establish tough cost containment throughout the health care system. Reform must include enforceable limits on private sector health spending, such as premium limits or ratesetting, if it is to be credible. There is little evidence to suggest that "competition" by itself—the approach relied on in both Senator Chafee's and the Cooper-Breaux bills—will adequately contain health costs.

Medicare savings will result from a system-wide approach to cost containment. But, absent system-wide reforms—and if reductions are unmatched in the private sector—the Medicare program could not sustain large reductions without creating quality and access problems for beneficiaries.

Over the past several years the Medicare program has been cut significantly—more than $80 billion in cumulative Medicare cuts throughout the 1980s, $43 billion in Medicare cuts enacted in OBRA90 and most recently, $56 billion in Medicare cuts enacted as part of OBRA93. Increasingly, we are hearing from our members that they are paying for these Medicare cuts in reduced access to care.

The President's plan proposes an additional *$118 billion* in Medicare cuts between 1996 and the year 2000. Senator Chafee's legislation would reduce Medicare spending by a similar amount. The Congressional Budget Office (CBO) recently found that while Medicare spending grew at an annual per-capita rate of 3.1 percent between 1985 and 1991, total U.S. health spending grew at an annual per-capita rate of 4.8 percent. In fact, CBO found that between 1975 and 1990 annual growth in Medicare costs per enrollee was consistently less than the growth in private insurance costs per enrollee, The reason for this difference is that Medicare is controlled through the federal budget process but private health care spending is not.

Absent system-wide cost containment, the Association will oppose any further efforts to cut Medicare. Moreover, the proposed Medicare savings, even if they can be achieved, are not a broad or permanent financing source for health care reform. Once the system is made more efficient, we will need to identify more lasting funding sources for the public cost of health care delivery.

Following is our assessment of some of the specific Medicare cuts now being proposed.

BENEFICIARY INCOME-RELATED PREMIUM

AARP has strongly opposed increasing the Medicare Part B premium for higher-income beneficiaries outside the context of health care reform. In the absence of comprehensive reform, a high-income premium would constitute nothing more than a cost-shift to beneficiaries without adequate control over system-wide spending.

We also believe that if Part B premiums are income-related, then private-sector premiums should be income-related as well. In 1994 alone, the federal government will "spend" $74 billion by providing tax breaks for employer-paid health care premiums. This provision is one-of the fastest growing tax expenditures in the budget.

It does not seem fair that taxpayers would continue to subsidize the health care premiums of a Wall Street executive with a salary of more than one million dollars a year while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced. *If Congress and the President believe that "income relating" premiums is a good idea for the elderly and disabled, then it is at least as good an idea for the rest of the country—including the Congress itself.* We estimate that income relating the tax subsidies for private insurance premiums in the same manner as Medicare Part B premiums would raise substantial revenue (Chart II).

HOME HEALTH COINSURANCE

The President's and Senator Chafee's proposals call for a 10 percent coinsurance on home health services, and the recently approved Ways & Means Health Subcommittee proposal includes a 20 percent coinsurance. These proposals would create a significant financial hardship for many Medicare beneficiaries, particularly those with low to modest incomes and the very old. For example, a 10 percent coinsurance requirement would cost the average Medicare home health user $425 in 1994, or $560 for the average user age 85 or older. This is on top of an estimated $2,500 in premium and out-of-pocket costs that older Americans will pay on average for medical care in 1994.

The home health coinsurance would also put physicians who treat the frailest and sickest Medicare beneficiaries in the difficult position of recommending care they know their patients cannot afford.

OUTPATIENT HOSPITAL COINSURANCE

Beneficiary coinsurance for hospital outpatient surgery, radiology, and diagnostic services far exceeds the standard 20 percent for other Part B services. This occurs because Medicare's payment is based on a blend of hospital and ambulatory surgery center costs and charges while *beneficiary coinsurance is based solely how much a hospital bills for the service.* Since the amount a hospital charges is usually higher than what Medicare approves, beneficiaries end up paying considerably more than the 20 percent coinsurance they pay for other Part B services. The Prospective Payment Assessment Commission (ProPAC) estimates that beneficiaries are paying anywhere from 37 to 54 percent in coinsurance. As beneficiaries increasingly receive services in hospital outpatient departments in lieu of inpatient care, the problem is getting worse.

None of the health care reform proposals being considered by Congress would correct this inequity. In fact, a proposal in the Health Security Act would actually make the situation worse. Under the proposal, Medicare would end up paying the Medicare-approved amount for a service minus what the beneficiary pays in coinsurance. For instance, if a hospital charged $300 but Medicare approved only $ 100, then the beneficiary would pay $60 (20 percent of $300) and Medicare would pay only $40 (which is $100 minus $60). As Medicare pays hospitals less for outpatient services, it puts pressure on hospitals to increase the amount charged to private patients. This results in a cost-shift to beneficiaries because beneficiary coinsurance is based on 20 percent of the same hospital charge paid by private patients. As charges go up, beneficiaries will pay more. This vicious cycle won't stop until beneficiaries pay 100 percent of the Medicare-approved amount and Medicare pays nothing.

REDUCTIONS IN MEDICARE PROVIDER PAYMENTS

There is a widening chasm between what Medicare reimburses and what the private sector pays for hospital and physician care. According to the Physician Payment Review Commission, Medicare now pays physicians on average, 59 percent of private rates. These gaps in payments have resulted in greater cost shifting onto the private sector and less willingness on the part of providers to treat Medicare patients.

The President's and Senator Chafee's proposals would further reduce Medicare payment updates for both hospital and physician services, even before the reductions in the Omnibus Budget Reconciliation Act of 1993 (OBRA93) go-into effect. At the same time, payment rates for Medicaid patients and the uninsured will increase to private insurance levels. The critical question for the Association is whether private sector cost containment proposals will *reduce* Medicare-private payment gaps and begin to address Medicare access problems. In the new system, Medicare beneficiaries could become the least profitable patients for providers to treat and experience the same access problems Medicaid patients currently must face.

THE STRUCTURE OF MEDICARE—BENEFICIARY OPTIONS

It is a reasonable objective to expand the availability of managed care options in Medicare in order to determine whether alternative delivery systems can gain widespread support among older Americans. At the present time, there is simply not sufficient enrollment in managed care plans to draw definitive conclusions about their appropriateness for or acceptability to Medicare beneficiaries. As of April 1994, there were approximately 1.9 million Medicare beneficiaries enrolled under risk contract HMOs—only 5 percent of total Medicare beneficiaries. An additional 450,000 beneficiaries participated in the Medicare Select program, HCFA's 15-state PPO demonstration. Thus, about 7 percent of all Medicare beneficiaries receive services through managed care organizations. This compares to about 45 million in the under-65 population enrolled in HMOs and an additional 122 million eligible to use PPOs—over 50 percent of the under-65 population.

AARP believes that Medicare beneficiaries should have managed care available as an option, and we support approaches that would level the playing field to enable managed care organizations to compete equally for Medicare beneficiaries. AARP has long supported improving the HMO reimbursement methodology under Medicare to encourage reasonable participation levels in the Medicare program on the part of health plans and to ensure that Medicare payments to such plans are set at appropriate levels and are cost effective.

We object, however, to proposals that seek to push beneficiaries into managed care by making critical benefits, such as prescription drugs, available only to those who enroll in managed care plans. That kind of incentive unfairly penalizes beneficiaries who remain in fee-for-service arrangements. Moreover, many Medicare beneficiaries, particularly in rural areas, simply do not have access to managed care plans.

AARP strongly supports retaining Medicare as a distinct program rather than dismantling it or forcing beneficiaries into state-based alliances or systems. We are not convinced that states would be able to develop and maintain consistent, high standards with respect to the oversight and enforcement that would be necessary to support a takeover of the Medicare program. It will take time and experience for the states to learn how to run a new system without adding 35 million more people. If Congress decides to grant a limited number of states the authority to integrate Medicare into broader statewide systems, the Association urges that the public be given ample opportunity to review and comment on such waiver requests and that states be required to *demonstrate*—with thorough Federal validation—not simply "assure," that:

- Medicare beneficiaries will receive the *same* benefits and protections as the under-65 population; and
- Medicare funds are earmarked so that states cannot divert such funds for other purposes.

FILLING THE GAPS IN MEDICARE

As Medicare savings result from health care reform, it will be essential to redirect those savings toward filling the major gaps in Medicare—chiefly coverage for long-term care and prescription drugs. On average, Medicare pays for only about half of Medicare beneficiaries' total health care costs. Out-of-pocket health care costs for older Americans, excluding nursing home care, are estimated to have increased by *122 percent* on average since 1987, roughly five times faster than the increase in

their income over the same period. These data are based on a comprehensive report on out-of-pocket expenses of older Americans which will be released next week by AARP and the Urban Institute.

LONG-TERM CARE

The inclusion of meaningful new home and community-based long-term care coverage in the health care reform legislation is vital to our members and their families and is critical to AARP's support for any health care reform proposal. We commend the President and cosponsors of S. 1757 for including home and community-based care in the bill. Regrettably, long-term care was excluded from both the Chafee and Cooper-Breaux bills.

Following are key reasons why AARP believes long-term care must be included in any health care reform proposal:

Health care coverage for acute illness alone will not give families real security and peace of mind. Over 37 million Americans have no insurance for hospital and doctor costs, but over 200 million have no insurance for long-term care costs. For Americans of all ages, paying the costs of long-term care, either for themselves or for family members, is one of their greatest concerns. For families, there is no difference between spending $20,000 on home care and spending $20,000 on hospital care. It is still $20,000 they do not have.

Long-term care is an intergenerational family issue. All family members are vulnerable—children born with a disability, parents paralyzed in an accident, or grandparents stricken with Alzheimer's disease. Approximately one-third of those who need home and community-based care are under 65 years of age.

Caregivers are being unfairly burdened. Family members provide the vast majority of long-term care to persons of all ages. But caregivers place their own health in jeopardy and frequently are forced to leave the labor market, thereby suffering not only short-term loss of income, but also long-term reduction in Social Security and private pension benefits.

Private sector solutions cannot work. The private market has not provided nor can it provide adequate and affordable protection against the cost of long-term care, particularly with regard to home and community-based services. Private long-term care insurance that provides meaningful coverage is very expensive and excludes people with pre-existing conditions or mental disorders. Few can afford the cost of meaningful private long-term care insurance.

Coverage for home and community-based care would give families new choices and help them avoid having to place loved ones in nursing homes. Right now, almost 4 out of 5 public long-term care dollars are spent on nursing home care. This reflects our system's institutional bias, while most would prefer to stay at home.

A new home and community-based care program would create new jobs and be good for the economy. For example, Lewin-VHI, Inc. estimates that the President's home care proposal will create approximately one million jobs. Absenteeism and burn-out among working caregivers will decline. Some adult disabled persons will be able to work with the new assistance available.

If we want the public to support health care reform it is critical that the proposal include long-term care. The findings from each of the four surveys that ICR Research Group has conducted between April, 1993 and January, 1994 show that bipartisan public support for health care reform increases *dramatically* when long-term care coverage is included. The most recent survey of 2,012 adults, conducted between January 26 and February 1, 1994 found that 64 percent of respondents were more likely to support a health care reform proposal that included comprehensive long-term care coverage and 42 percent were much less likely to support a health care proposal with no long-term care coverage.

It makes little sense to provide financial protection against the cost of an acute illness but leave people vulnerable if they suffer from a chronic and disabling condition. The need for these services is interrelated. Results from research conducted on the Social Health Maintenance Organization (SHMO) demonstrations in the late 1980's indicate that: 1) about 70 percent of initial referrals for community-based long-term care originated from the medical care system; (2) 37 percent of the care plans developed for home and community care included concurrent authorization for medically necessary skilled services; and (3) individuals' levels of disability frequently changed and were due to acute episodes of illness.

To make long-term care coverage affordable and accessible to all Americans, the Association believes that the ideal solution is a social insurance program, similar to Medicare and Social Security, that would provide a comprehensive set of benefits in the home and community, as well as in nursing homes. Other fundamental principles that underlie AARP's views on long-term care include: (1) effective cost con-

tainment mechanisms: (2) financing which is equitable broadly based, and affordable to all individuals; (3) coordination between the acute and long-term care systems to assure a continuum of care across an individual's lifetime: (4) assurance of high quality care: and (5) support for informal caregivers.

It is important to point out that the Health Security Act would strictly limit new federal expenditures for home and community-based care by (1) not providing an individual entitlement to services; (2) capping federal expenditures; (3) leaving nursing home coverage largely to the private market, with new standards and tax incentives; (4) imposing stringent eligibility criteria; (5) providing for a long seven-year phase-in period; and (6) providing for income-related copayments. It is also important to note that most states will realize significant savings from this provision due to Medicaid offsets derived from the greatly enhanced federal match rate under the proposed new program (on average, 85 percent vs. 57 percent under Medicaid).

It is our hope that new coverage for home and community care will be included in health care reform legislation will receive strong bipartisan support (as it does with Americans in all age groups). AARP will work with Congress to help fashion a long-term care benefit that is both meaningful and affordable.

PRESCRIPTION DRUGS

Currently, about *70 million* Americans lack prescription drug coverage, and those who cannot afford to pay for their medications out-of-pocket are too frequently denied access to essential, often life-saving drug therapies. This can compromise their health status and make them more likely to receive unnecessary and more expensive care. *AARP firmly believes that any viable health care reform proposal must include a universal prescription drug benefit.*

This problem is most severe for older Americans as the combined effects of high prices, heavy utilization, and the absence of affordable insurance coverage for prescription drugs have substantially reduced their access to needed drug therapies. A 1992 survey sponsored by AARP showed that:

- older Americans use significantly more prescription drugs than other age groups to maintain their health;
- prescription drug insurance coverage declines rapidly as age increases (Chart III); and
- out-of-pocket costs for prescription drugs are significantly higher for older Americans than for their younger counterparts.

In addition, fifty-eight percent of older Americans surveyed reported that, compared to other health care costs, they had a problem paying for their prescriptions; over half of these said it was a *major* problem. Moreover, about ten percent said they had to cut back on necessary items, such as food and heating fuel, to afford their medications.

AARP believes that a meaningful Medicare prescription drug benefit must include the following basic elements:

- guaranteed access to needed drug therapies;
- effective cost containment;
- stable, broad-based, and equitable financing;
- protections for low-income beneficiaries; and
- provisions that encourage appropriate prescribing, monitoring, and use of medications.

AARP is pleased that the President's proposal includes a Medicare drug benefit that adequately addresses most of these elements. We are concerned that the proposals offered by Senators Breaux, Chafee, and Durenberger would not guarantee access to needed medication nor address most of the other elements we believe are important.

AARP strongly believes that *effective cost containment* must be part of any prescription drug benefit. If effective cost containment is not included, the benefit may quickly become unaffordable. This was clearly the case during the development of the Medicare Catastrophic Coverage Act (MCCA). Due to the lack of effective cost containment, the projected cost of the MCCA drug benefit (and the resulting estimates of premiums to be paid by beneficiaries) skyrocketed even before the bill made its way through the conference committee.

We believe the President's proposal includes effective cost containment through payment limits that encourage the use of generic drugs and through rebates required from manufacturers. Moreover, the President's proposal retains adequate incentives for research and development. We recognize, however, that other cost containment mechanisms may be effective as well. For example, a few major pharmaceutical manufacturers are offering potentially meaningful alternatives for providing drug coverage to Medicare beneficiaries while controlling costs. AARP believes that

cost containment mechanisms should not impede convenient beneficiary access to needed medications or pharmacy counseling. Although we have not seen the details of these alternative proposals, we have expressed a willingness to review them. We recognize that cooperation from the industry could help to expedite Congressional action on this important benefit.

AARP is concerned about the "voluntary" price restraint proposals currently advocated by the pharmaceutical industry. The industry claims that its "voluntary" efforts are working and backs its claim by citing the Producer Price Index (PPI) for pharmaceuticals, which was 3.1 percent in 1993. According to a recent Senate Special Committee on Aging report, however, drug manufacturer price inflation at the retail level—where most older Americans buy prescription medications—continued to increase much faster than general inflation in 1993. In fact, according to the report, "forty of the top 200 drugs increased in price at the retail level more than twice the rate of general inflation, which was 2.7 percent in 1993."

Clearly, voluntary cost containment is entirely inadequate and merely perpetuates cost shifting from the inpatient market, where HMOs and hospitals negotiate deep discounts from manufacturers, to the outpatient or retail market, where similar discounts are not offered.

We look forward to continuing to work with you and your colleagues to ensure that a prescription drug benefit that guarantees access and contains costs is a part of the health care reform proposal that emerges from this committee.

PREVENTION

Medicare does not cover most preventive services needed by beneficiaries. In fact, only in the last few years has Medicare covered biennial mammograms and pap smears. Beneficiaries still do not have coverage for life-saving preventive services such as colorectal and prostate cancer screenings, and periodic checkups. Regrettably, neither the President's nor Senator Chafee's plans would change this shortsighted Medicare policy. We commend the co-sponsors of the Cooper-Breaux proposal to expand Medicare coverage in this area. AARP supports coverage of preventive benefits that are determined to be appropriate and effective for Medicare beneficiaries.

LOW-INCOME PROTECTIONS

Medicare does not provide adequate protections for low-income beneficiaries. About 4.5 million Medicare beneficiaries are dually eligible for Medicaid or receive full or partial assistance for Medicare premiums deductibles, and coinsurance through the Qualified Medicare Beneficiary (QMB) program. The QMB program pays Medicare premiums and all Medicare cost sharing for persons below the poverty level but pays only for Part B premiums for those between 100 and 120 percent of the poverty level.

Still, almost 2 million Medicare beneficiaries eligible for the QMB program do not receive benefits, and many more low-income beneficiaries above the QMB threshold need assistance to pay for care not covered by Medicare.

Both the President's plan and the Chafee plan would expand federal subsidies for the low-income—but only for those under the age of 65. AARP strongly recommends that health care reform legislation offer equal protections for low-income Medicare beneficiaries.

OUT-OF-POCKET LIMITS

Unlike many employer-sponsored health plans today, Medicare does not limit the amount individuals must pay out of pocket for covered services. As a result, beneficiaries who are sicker and require substantial hospital and physician care often pay thousands of dollars each year in cost-sharing. Or, they can buy expensive medigap plans to help protect against these high costs. Out-of-pocket health care costs for older Americans—even when premium payments and long-term care costs are excluded—are substantially more than for younger populations.

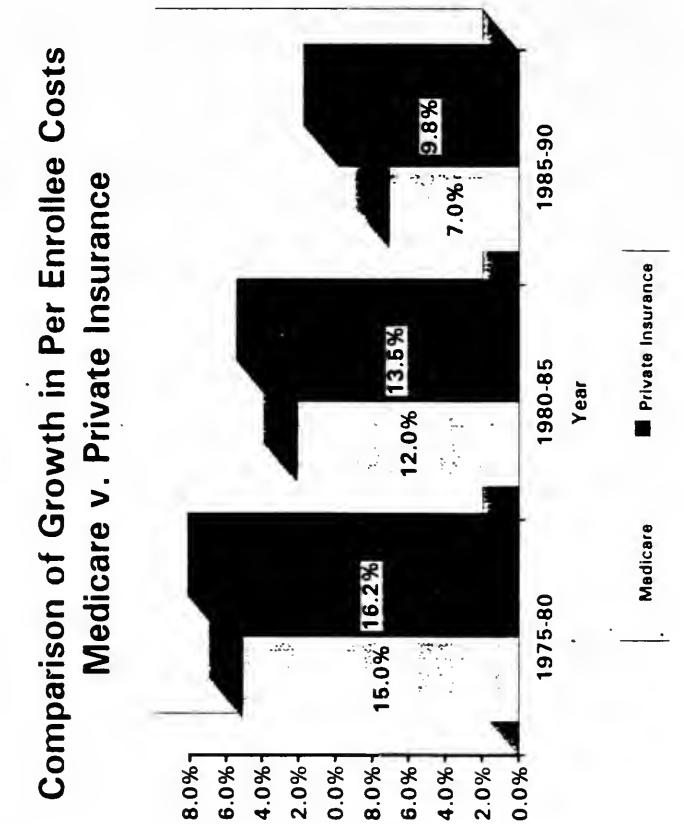
Unfortunately, neither the President's nor Senator Chafee's plans establish an annual out-of-pocket limit on cost-sharing for Medicare beneficiaries.

CONCLUSION

In conclusion, Mr. Chairman, AARP believes that Medicare can and should be maintained and strengthened as part of health care reform. In so doing, we will help achieve health security for all Americans and begin to move toward a more comprehensive system of health care.

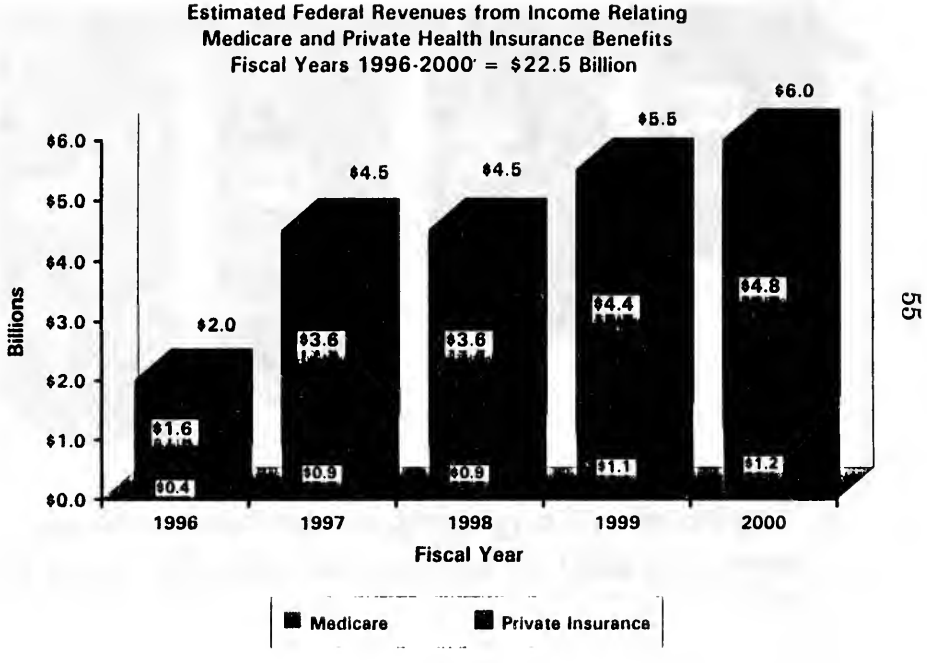
We commend the President, as well as the many members of Congress on both sides of the aisle who have brought the issue of health care reform to this stage. AARP will work with the Congress in a bipartisan way to ensure that comprehensive benefits are guaranteed to Americans of all ages in a final health care plan. Strengthening Medicare is a critical step toward that guarantee.

Chart I



Source: CBO calculations from the National Health Expenditure Accounts, Medicare Program Data, and Data from HIAA (2/14/92)

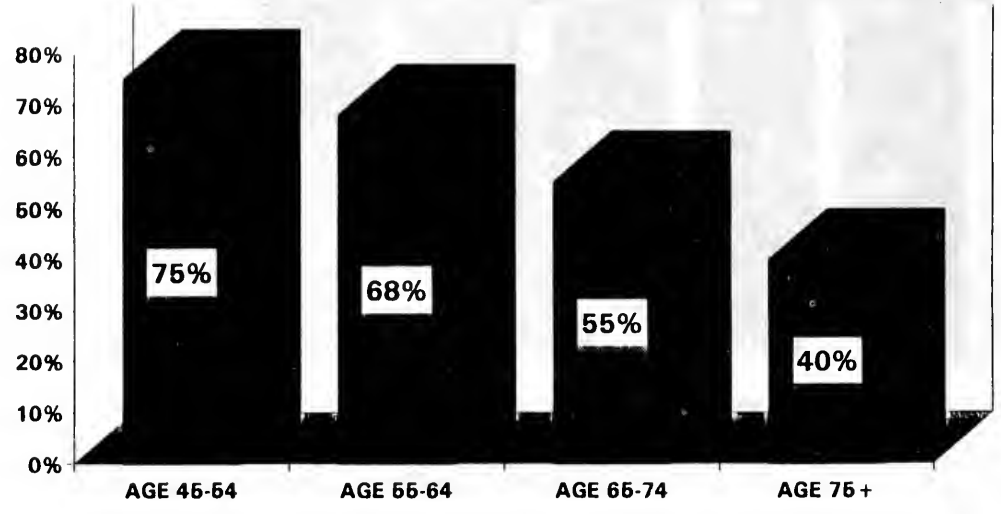
Chart II



Source: Medicare est. based on Admin.'s 11/93 est. of income relating the Part B premium as proposed in the HSA.
Private insurance est. based on income relating private health insurance premiums using the same income thresholds.

Chart III

Drug Coverage Declines Rapidly as Age Increases
(Percent Having Prescription Drug Coverage)



Source: Chilton Research Services for AARP, 1992.

PREPARED STATEMENT OF DICK DAVIDSON

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. On behalf of AHA's 5,000 institutional members, I am pleased to have the opportunity to testify here today. The issues we are discussing—the role Medicare will play in financing health care reform, and whether Medicare beneficiaries will become part of the reformed health care system—are absolutely central to the reform debate.

Hospitals strongly disagree with the idea that Medicare reductions are a reasonable way to finance reform. We don't believe there are resources in the system to allow such large—truly unprecedented—reductions without seriously undermining both hospitals' ability to carry out the changes that will be needed under reform and hospitals' responsibility to provide high quality care for Medicare patients, and for all patients. Today, we draw on new data, which we asked the health consulting firm Lewin-VHI to develop.

HOSPITALS SUPPORT FUNDAMENTAL REFORM

As we begin, however, I want to be very clear about one thing. *Hospitals are firm supporters of fundamental health care reform.* I couldn't be prouder of the work our members have done in developing a progressive, practical vision for reform. Our vision is centered on three core objectives:

- Guaranteed coverage and access to care;
- Restructuring the delivery system to deliver more efficient and effective care; and
- fair financing.

We use our three goals as a template, against which we measure all other reform proposals. No proposal now on the table would achieve all our goals—so we do not endorse any single reform plan. We are, however, working to support elements of proposals that do move us toward our reform vision. And, we are providing constructive suggestions to strengthen areas we feel fall short. That is the procedure we are following today, explaining to you why proposed Medicare reductions and the failure to integrate the Medicare population in reform undermine achieving our fundamental goals.

Many of the congressional health care reform proposals would make unprecedented cutbacks in the rate of increase in Medicare spending to pay for reform. The Administration's proposal would reduce Medicare spending by $118 billion over the next six years in order to finance health care reform. This is twice the size of any reductions previously taken from Medicare. Other proposals, including those offered by Rep. Pete Stark (D-CA), Sen. John Breaux (D-LA)/Rep. Jim Cooper (R-TN), and Sen. John Chafee (R-RI) also would reduce Medicare spending by significantly more than ever before.

It's important to remember that these proposed reductions come on top of OBRA 1993 legislation, which cut $56 billion from projected Medicare spending; and on top of $43 billion in reductions approved just three years earlier as part of the 1990 budget summit agreement. Furthermore, outside of the health care reform debate, many members of Congress favor limiting future spending on entitlement programs, including Medicare and Medicaid. Others support a requirement to balance the federal budget on an annual basis—an approach that would hit hard on the largest federal programs, particularly Medicare.

We should also put these reductions in the context of current inadequate Medicare payment rates. The Prospective Payment Assessment Commission (ProPAC)—the independent agency set up by Congress to oversee Medicare—has concluded that Medicare payments to hospitals *already* fail to keep pace with hospitals' costs.

NEW ESTIMATES ON IMPACT OF REDUCTIONS

The Lewin-VHI estimates give us a preliminary forecast of what could happen in the future with Medicare reductions of the magnitude envisioned in the Administration's reform proposal. It is important to note that these estimates do not pretend to predict the future with any certainty—they are highly sensitive to underlying assumptions about future growth in hospital costs. They are, however, illustrative of the kinds of pressures that hospitals face if Medicare spending reductions alone of this size are enacted. And the magnitude of those pressures is sobering:

- By the *year 2000,* after six years of spending reductions, Medicare could pay hospitals *only 71 cents for every dollar of inpatient care delivered* to a Medicare patient.

- *The spending reductions could make the Medicare program an even poorer payer than today's Medicaid program,* which currently pays hospitals about 82 cents on the dollar.
- While most hospitals and all states are affected, *teaching hospitals, large urban areas,* and communities with *hospitals serving a disproportionately large number of low-income patients* would be particularly hard hit.

The study uses Medicare reductions contained in the Administration's plan because it was the most detailed available at the time the study began. Among the health care providers and Medicare beneficiaries who would be affected by the President's spending reductions, Administration estimates indicate that hospitals are hardest hit, taking $70 billion of the $118 billion in proposed reductions.

The data show that reductions like these, with no accompanying reform steps such as expanding health care coverage, could cause significant financial losses for hospitals. While arguably losses might be mitigated by reducing the rate of growth in hospital costs, hospitals' ability to squeeze down costs is limited. As ProPAC recently reported, 60 percent of hospitals' cost increases from 1985 to 1989 were due to factors beyond hospitals' control—inflation in the general economy (39 percent) and increasing complexity of patients treated (21 percent). Hospitals are deeply concerned that losses of the size estimated by Lewin-VHI cannot be made up through increased efficiency and will therefore undermine our ability to deliver high quality care and to participate in health care reform.

One reason for our concern is that the current health care environment, with its growth in managed care, means that Medicare reductions will be felt by hospitals, patients, and communities more deeply than ever before. In the past, hospitals have been able to shift unfunded costs to other non-government payers—meaning higher costs for these patients and their employers. Managed care contracts, however, narrow this option. So, too, do the growing number of private insurers who negotiate discounted prices. And, under many of the comprehensive health care reform proposals that seek to limit private sector spending, the ability to cost-shift is reduced even more.

HOSPITAL CHOICES ARE FEW UNDER MEDICARE REDUCTIONS

This leaves hospitals with unpalatable choices for controlling costs: reduce the size of the hospital work force, or reduce services and programs, or both. Hospitals are reluctant to reduce their work force, because doing so jeopardizes their ability to do their job well—hospitals are very labor-intensive institutions. Similarly, it is often easier to eliminate certain services than to restructure services in order to cross-subsidize care. Hospitals will continue to work to provide care more efficiently. But, given these economic facts of life, additional Medicare payment reductions would be felt more deeply than ever by hospitals, patients, and the communities they serve.

Such reductions also threaten the ability of hospitals to participate in health care reform. Expanding the covered population, restructuring the delivery system, reconfiguring hospitals and other services for the future, and investing in new technologies to meet the demands of the new system—all will need adequate resources. For example, the infrastructure improvements we all endorse in order to reduce administrative costs—electronic billing, computerized patient records, new information systems—will require an up-front investment.

Specifically for hospitals, getting beyond the traditional acute care role that will be necessary under reform would be jeopardized by excessive spending reductions. For example, consumer education, wellness, and outreach programs—not funded by the current system—are among the most vulnerable when finances are squeezed.

Alternative sources of financing health care reform are available to spread the cost of reform more broadly, beyond hospitals, physicians, and other health care professionals who will already be deeply affected by change. For example, more than $75 billion could be raised by increasing or imposing federal excise taxes on handguns, assault weapons, ammunition, tobacco and alcohol. Significantly, the use of many of these items often contributes to poor health and hospital emergency department visits.

IMPLICATIONS FOR PATIENTS AND COMMUNITIES

Hospitals want to see reform done right. Many hospitals have already begun to provide care in more cost-effective, collaborative ways. For example, ProPAC reports that the number of hospitals with health maintenance organization and preferred provider contracts increased from 37 percent in 1985 to nearly 62 percent in 1992. And, ProPAC also reports that in 1993, more than 30 percent of the nation's hospitals were involved in collaborative relationships with physicians, whether a formal

physician/hospital organization (14 percent), a management services organization (7 percent), or a foundation that negotiated managed care contracts for the hospital and physicians as a unit (4 percent). Forming collaborative provider networks and reconfiguring services for the future, however, present major financial and organizational challenges for hospitals. It is unfair to expect hospitals to *deliver* on health care reform and *pay* for it, too, through deeper Medicare spending reductions.

We understand that not all hospitals will survive in a reformed health care system. In fact, the kind of massive restructuring that we propose will result in mergers, consolidations, and closures—this is the most responsible and thoughtful way to reduce excess capacity and eliminate overlap and duplication in high technology and services.

But the kinds of indiscriminate Medicare spending reductions proposed hit hardest on the most financially vulnerable institutions—those barely breaking even or already operating at a loss and those treating large numbers of Medicare beneficiaries. These hospitals may be the very facilities that need to remain open to assure access and coverage to underserved populations and achieve the broader goals of health care reform. Hospital closures should be based on the needs of communities, not on a particular hospital's financial health. Decisions to merge or close facilities should be made at the local level within the community.

RESTRUCTURED DELIVERY SYSTEM AND MEDICARE "INTEGRATION"

The size of proposed Medicare reductions presents another obstacle for achieving fundamental health care reform—it creates a greater-than-ever schism between how we pay for and provide care for Medicare beneficiaries and for the rest of the population. This is the opposite direction of where we want to go.

Currently, Medicare beneficiaries are presented with a delivery system that stresses specialization over primary care; administrative complexity over simplicity; and fragmented care rather than coordinated care. Many of us have had the experience of helping an elderly friend or family member deal with stacks of confusing bills and forms, or trying to coordinate their medical care between the physician and the hospital or some other health care provider.

At the same time, some Medicare beneficiaries still face barriers to receiving basic primary care. According to the Physician Payment Review Commission, the independent congressional commission overseeing payment to physicians under Medicare and Medicaid, the lack of availability of primary care is the most common complaint made by Medicare beneficiaries.

We believe it's absolutely essential that the Medicare population be part of the same reformed system as other Americans—that Medicare beneficiaries be "integrated" into reform. And, just as strongly, we believe that the reformed health care system include the kinds of collaborative provider networks we touched on earlier. In AHA's reform vision, such collaborative arrangements are called "community care networks(SM)"—locally based, networks of hospitals, doctors, other health care providers, and social service and community agencies, working together to improve the health of people in the community.

Community care networks focus on primary care, prevention, and coordinating care to ensure that all patients—young and old—receive the right kind of care at the right time and in the most appropriate setting. A capitated payment system—an upfront fee for each enrolled person—improves efficiency and creates the proper incentives for providers to work together to keep patients healthy.

Networks would also help patients navigate the complex maze of available health care services. This is particularly important for Medicare patients, because they use more services more often.

In addition, if the Medicare and non-Medicare populations are part of the same reformed health care system, providers would have the same incentives to deliver appropriate and cost-effective care to Medicare beneficiaries as they would for other patients. Imagine hospitals trying to improve coordination and efficiency if more than 30 percent of what they do is driven by a set of incentives that represent the inefficiencies of our current fragmented system—which would be the case if Medicare, comprising, on average, a third of hospitals' patient revenue, remains out of the reformed health care system of the future.

But it is not clear that these opportunities for better patient care and more efficient case management will be available to Medicare beneficiaries and encouraged under health care reform. As a first step, all reform plans should encourage Medicare beneficiaries to join managed care plans where available. Interest and partici-

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pation could be increased through education and information about the advantages managed care offers, by providing financial incentives or increased benefits for joining managed care plans, and by expanding the types and numbers of managed care plans offered to Medicare beneficiaries to allow them more flexibility to choose their own physician. We support these and a number of similar initiatives contained in Sen. Dave Durenberger's (R-MN) bill, S. 1996, that work toward these ends.

Integrating Medicare patients into the reformed delivery system makes good public policy sense. But more importantly, it makes good sense for the older Americans we serve.

CONCLUSION

Hospitals have been and will continue be a constructive force as our nation moves toward a fundamentally reformed health care system. We believe our role on the front line of health care delivery gives us valuable insight and experience to bring to that process. We are willing to contribute to the shared sacrifice that will inevitably be part of reform. Our vision of reform does just that, with its incentives for economic discipline and dramatic changes in the structure of health care delivery.

What we are not willing to do, however, is jeopardize the quality of the health care we deliver to our Medicare patients, and to all our patients. We firmly believe that the Medicare spending reductions proposed in the Administration's plan and in many other congressional health reform proposals would undercut our ability to deliver high quality care.

Continued Medicare reductions are likely to result in further staffing reductions, delays in purchasing new equipment, postponing the upgrading of facilities, closing certain services in order to maintain other services at peak quality, and jeopardizing the research and education programs that have kept America's health system on the cutting edge of scientific development.

In addition, we believe it is absolutely essential that the Medicare population be part of the same reformed system as other Americans, and that the reformed system expand managed care opportunities for Medicare patients and for all patients. Only through such Medicare "integration" will beneficiaries have strong incentives to seek cost-effective care and their providers have consistent incentives to treat them in the most cost-effective way.

It is for these reasons that we urge you to reject Medicare reductions contained in the Administration's plan and in other congressional reform proposals and instead consider the many alternative sources of financing available as your committee goes about the difficult work of shaping health care reform. And, we urge you to include Medicare beneficiaries under the reform umbrella as the best way to work toward more cost-effective delivery of care for these patients.

Table 1:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by Hospital Group Under OBRA 93

		Pre OBRA 93			OBRA 93						
	N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
All Hospitals	5185	-3.3%	-4.0%	-4.1%	-6.4%	-8.8%	-10.9%	-11.7%	-11.9%	-12.0%	-12.2%
All Teaching Hospitals	1008	1.1%	-0.5%	-0.3%	-2.1%	-4.4%	-6.3%	-7.1%	-7.2%	-7.1%	-7.1%
Major Teaching	213	8.3%	7.8%	8.3%	7.6%	5.7%	4.1%	3.5%	3.5%	3.7%	4.0%
Minor Teaching	795	-2.3%	-4.3%	-4.4%	-6.6%	-9.2%	-11.3%	-12.1%	-12.3%	-12.3%	-12.4%
Non-Teaching	4177	-7.8%	-7.7%	-7.9%	-10.9%	-13.3%	-15.7%	-16.6%	-16.8%	-17.1%	-17.4%
Type of Hospital											
Urban	2914	-3.1%	-4.5%	-4.6%	-6.1%	-8.6%	-10.7%	-11.4%	-11.6%	-11.6%	-11.7%
Large Urban	1545	-1.9%	-3.6%	-3.5%	-4.5%	-7.0%	-9.0%	-9.8%	-9.9%	-9.9%	-10.0%
Other Urban	1369	-4.9%	-6.0%	-6.2%	-8.5%	-11.0%	-13.1%	-13.9%	-13.9%	-14.1%	-14.2%
Rural	2271	-4.2%	-0.7%	-0.8%	-8.5%	-10.1%	-12.7%	-14.0%	-14.6%	-15.1%	-15.7%
Sole Community	541	1.0%	1.6%	1.6%	-9.8%	-9.9%	-12.6%	-13.9%	-14.5%	-15.1%	-15.8%
Sole Comm and Rural Referral	46	4.1%	9.4%	9.4%	-2.1%	-5.0%	-7.5%	-8.6%	-9.1%	-9.6%	-10.0%
Rural Referral	188	-5.9%	-3.1%	-3.0%	-9.1%	-12.1%	-14.5%	-15.6%	-15.9%	-16.3%	-16.6%
Other Rural	1496	-6.4%	-1.7%	-1.8%	-8.8%	-9.6%	-12.3%	-13.7%	-14.5%	-15.3%	-16.0%
Payment Adjustments											
IME & Disp Share	483	4.1%	2.8%	3.2%	1.9%	-0.3%	-2.2%	-3.0%	-3.1%	-2.9%	-2.8%
IME Only	774	-5.0%	-5.5%	-6.3%	-8.5%	-11.1%	-13.6%	-14.7%	-15.1%	-15.4%	-15.7%
Disp Share Only	383	-4.0%	-5.4%	-5.5%	-8.1%	-10.7%	-12.7%	-13.6%	-13.6%	-13.7%	-13.8%
None	3545	-6.9%	-7.0%	-7.1%	-10.0%	-12.3%	-14.6%	-15.4%	-15.5%	-15.8%	-16.1%
Medicare Proportion of Rev.											
Over 60%	1175	-6.6%	-7.2%	-7.4%	-11.2%	-13.7%	-16.3%	-17.4%	-17.8%	-18.2%	-18.5%
Under 60%	4010	-2.7%	-3.5%	-3.6%	-5.7%	-8.0%	-10.1%	-10.9%	-11.0%	-11.1%	-11.2%
Size											
1-50 Beds	1362	-4.5%	-2.1%	-2.4%	-9.3%	-10.5%	-13.3%	-14.7%	-15.5%	-16.4%	-17.3%
50-99 Beds	1123	-6.0%	-4.7%	-5.0%	-10.1%	-11.8%	-14.5%	-15.9%	-16.6%	-17.2%	-17.9%
100-199 Beds	1226	-5.8%	-5.5%	-5.8%	-9.0%	-11.5%	-14.0%	-15.0%	-15.4%	-15.7%	-16.1%
200-299 Beds	670	-5.6%	-6.3%	-6.5%	-8.7%	-11.4%	-13.6%	-14.5%	-14.8%	-14.9%	-15.1%
300+ Beds	804	-1.0%	-2.5%	-2.5%	-4.0%	-6.3%	-8.2%	-8.8%	-8.8%	-8.7%	-8.7%
Ownership											
Church	674	-3.9%	-4.9%	-5.2%	-7.0%	-9.3%	-11.2%	-11.9%	-11.9%	-11.9%	-11.9%
Voluntary	2327	-2.9%	-3.8%	-3.8%	-6.4%	-8.9%	-11.2%	-12.1%	-12.4%	-12.5%	-12.7%
Proprietary	748	-5.6%	-6.5%	-6.4%	-7.4%	-9.4%	-11.2%	-11.5%	-11.2%	-11.2%	-11.3%
Government	1436	-1.6%	-1.6%	-1.6%	-4.8%	-6.9%	-9.2%	-10.2%	-10.5%	-10.8%	-11.1%

* Actual

Table 2:

Projected Medicare PPS Inpatient Operating Margins by State Under OBRA 93

			Pre OBRA 93			OBRA 93						
		N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State												
	Alabama	116	-2.5%	-3.3%	-3.3%	-5.6%	-7.5%	-9.3%	-9.5%	-9.3%	-9.4%	-9.5%
	Alaska	16	-1.4%	-2.6%	-2.7%	-13.4%	-14.7%	-16.5%	-16.6%	-16.3%	-16.4%	-16.6%
	Arizona	57	1.2%	0.4%	0.5%	-0.7%	-2.2%	-3.3%	-3.0%	-2.3%	-1.9%	-1.6%
	Arkansas	81	-0.1%	-1.5%	-1.9%	-8.3%	-10.7%	-13.2%	-14.1%	-14.5%	-15.0%	-15.6%
	California	437	-0.1%	-2.4%	-2.4%	-2.4%	-4.4%	-6.0%	-6.1%	-5.9%	-5.9%	-5.9%
	Colorado	67	-4.4%	-2.7%	-2.6%	-5.1%	-7.3%	-9.3%	-9.6%	-9.6%	-10.2%	-10.6%
	Connecticut	34	-11.6%	-15.1%	-14.6%	-16.3%	-20.1%	-23.3%	-25.7%	-26.6%	-27.4%	-28.1%
	Delaware	7	-12.0%	-12.4%	-12.0%	-14.8%	-16.6%	-18.3%	-18.4%	-18.0%	-17.8%	-17.6%
	Washington DC	9	-3.5%	-7.2%	-7.4%	-9.1%	-11.2%	-12.8%	-12.9%	-12.5%	-12.5%	-12.5%
	Florida	219	-9.2%	-10.3%	-9.7%	-10.3%	-12.2%	-13.6%	-13.5%	-12.9%	-12.6%	-12.3%
	Georgia	160	-7.8%	-6.6%	-6.8%	-9.6%	-11.9%	-14.1%	-14.8%	-14.9%	-15.4%	-15.8%
	Hawaii	20	-14.1%	-22.0%	-22.7%	-28.8%	-32.2%	-35.7%	-37.1%	-37.6%	-38.6%	-39.5%
	Idaho	42	-0.1%	3.2%	1.2%	-6.6%	-8.7%	-11.0%	-11.7%	-12.0%	-12.4%	-12.9%
	Illinois	204	-7.0%	-9.1%	-8.7%	-10.3%	-12.3%	-14.0%	-15.2%	-15.0%	-14.9%	-14.8%
	Indiana	116	-11.5%	-12.0%	-11.9%	-15.3%	-17.9%	-20.1%	-21.7%	-21.8%	-22.2%	-22.5%
	Iowa	123	-6.8%	-4.8%	-5.1%	-10.1%	-12.4%	-14.8%	-15.6%	-15.9%	-16.3%	-16.6%
	Kansas	131	-5.6%	-6.3%	-6.5%	-10.2%	-12.1%	-14.2%	-14.7%	-14.7%	-15.0%	-15.3%
	Kentucky	104	-4.2%	-5.3%	-5.2%	-8.1%	-9.9%	-11.8%	-12.1%	-11.9%	-11.9%	-11.9%
	Louisiana	138	-11.2%	-11.6%	-11.3%	-11.5%	-13.3%	-15.0%	-15.2%	-14.8%	-14.8%	-14.9%
	Maine	39	-9.0%	-13.1%	-13.6%	-16.1%	-18.8%	-21.7%	-24.1%	-24.8%	-25.6%	-26.4%
	Maryland **	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	Massachusetts	99	2.7%	1.3%	0.9%	-1.2%	-3.9%	-6.2%	-7.7%	-8.1%	-8.4%	-8.6%
	Michigan	171	1.1%	-1.2%	-0.8%	-3.6%	-5.6%	-7.5%	-8.7%	-8.6%	-8.5%	-8.4%
	Minnesota	149	2.8%	1.4%	0.4%	-3.5%	-6.1%	-8.7%	-9.8%	-10.4%	-11.1%	-11.8%
	Mississippi	104	-1.3%	-0.8%	-0.8%	-6.0%	-7.7%	-9.9%	-10.4%	-10.6%	-10.8%	-11.0%
	Missouri	132	-4.3%	-7.8%	-7.2%	-9.9%	-12.0%	-13.8%	-14.0%	-13.8%	-13.9%	-13.9%
	Montana	54	-0.9%	-0.2%	-0.2%	-8.5%	-10.2%	-12.3%	-12.8%	-12.9%	-13.3%	-13.7%

** Projections were not made for Maryland, which operates an all-payer rate setting system under a waiver from the Medicare program.

* Actual

Table 2:

Projected Medicare PPS Inpatient Operating Margins by State Under OBRA 93

			Pre OBRA 93			OBRA 93						
		N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State												
	Nebraska	89	-14.6%	-13.0%	-13.3%	-12.3%	-14.1%	-16.0%	-16.3%	-16.1%	-16.3%	-16.4%
	Nevada	22	-4.6%	-4.8%	-4.1%	-3.5%	-4.6%	-5.2%	-4.6%	-3.5%	-3.4%	-3.3%
	New Hampshire	26	-18.5%	-16.6%	-16.3%	-13.5%	-16.3%	-18.8%	-20.5%	-20.8%	-21.0%	-21.2%
	New Jersey	88	-9.6%	-11.4%	-10.8%	-12.7%	-16.7%	-20.3%	-22.3%	-23.7%	-24.3%	-24.8%
	New Mexico	35	9.4%	9.4%	9.5%	3.7%	2.3%	0.5%	0.2%	0.3%	0.3%	0.3%
	New York	218	7.8%	8.7%	8.5%	6.9%	3.8%	0.7%	-1.3%	-2.9%	-2.6%	-2.4%
	North Carolina	126	-6.1%	-1.5%	-2.3%	-5.0%	-8.1%	-11.0%	-12.4%	-13.3%	-14.0%	-14.6%
	North Dakota	48	-4.5%	-1.8%	-1.3%	-6.7%	-8.0%	-9.5%	-9.4%	-9.0%	-8.7%	-8.5%
	Ohio	185	-6.5%	-6.7%	-6.7%	-11.3%	-13.7%	-15.6%	-17.1%	-17.0%	-17.0%	-17.0%
	Oklahoma	115	0.8%	-0.1%	0.0%	-6.9%	-9.1%	-11.4%	-12.0%	-12.3%	-12.7%	-13.1%
	Oregon	65	8.1%	4.1%	4.2%	-2.1%	-4.2%	-6.1%	-6.5%	-6.5%	-6.6%	-6.8%
	Pennsylvania	218	-2.4%	-3.0%	-2.9%	-4.9%	-7.3%	-9.2%	-9.7%	-9.8%	-9.9%	-10.1%
	Rhode Island	12	3.8%	1.9%	4.9%	0.1%	-2.5%	-4.7%	-6.0%	-6.3%	-6.4%	-6.6%
	South Carolina	69	-13.9%	-9.3%	-9.6%	-11.6%	-14.3%	-16.9%	-17.9%	-18.4%	-18.5%	-18.7%
	South Dakota	53	-2.5%	-2.6%	-2.8%	-8.3%	-9.8%	-11.4%	-11.7%	-11.6%	-11.7%	-11.8%
	Tennessee	132	-6.9%	-10.6%	-10.4%	-12.4%	-14.3%	-16.1%	-16.4%	-16.2%	-16.3%	-16.4%
	Texas	398	-6.8%	-7.6%	-9.6%	-9.9%	-12.0%	-13.9%	-14.2%	-14.0%	-14.2%	-14.4%
	Utah	39	7.5%	9.2%	9.5%	5.4%	3.4%	1.6%	1.3%	1.2%	1.1%	0.9%
	Vermont	15	-10.9%	-11.2%	-11.8%	-18.1%	-21.0%	-24.2%	-26.7%	-27.4%	-28.0%	-28.6%
	Virginia	99	-6.2%	-6.9%	-7.0%	-10.8%	-13.2%	-15.5%	-16.1%	-16.3%	-16.6%	-16.9%
	Washington	92	2.7%	2.3%	1.6%	-1.8%	-4.3%	-6.5%	-7.2%	-7.5%	-7.9%	-8.4%
	West Virginia	58	-7.1%	-5.4%	-5.4%	-14.1%	-16.8%	-19.5%	-20.5%	-21.0%	-21.5%	-22.1%
	Wisconsin	128	0.6%	0.8%	0.5%	-4.7%	-6.9%	-8.9%	-10.4%	-10.5%	-10.8%	-11.1%
	Wyoming	26	-1.8%	-12.6%	-10.7%	-23.7%	-24.7%	-26.7%	-27.1%	-26.9%	-27.4%	-27.3%

* Actual

Table 3:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by Hospital Group Under the Health Security Act

	N	Pre OBRA 93			OBRA 93	Health Security Act					
		1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
All Hospitals	5185	-3.3%	-4.0%	-4.1%	-6.4%	-10.4%	-14.8%	-17.5%	-23.7%	-26.3%	-28.9%
All Teaching Hospitals	1008	1.1%	-0.5%	-0.3%	-2.1%	-7.5%	-14.0%	-16.6%	-24.4%	-26.8%	-29.3%
Major Teaching	213	8.3%	7.8%	8.3%	7.6%	0.2%	-10.2%	-12.6%	-24.9%	-27.0%	-29.2%
Minor Teaching	795	-2.3%	-4.3%	-4.4%	-6.6%	-11.0%	-15.6%	-18.3%	-24.2%	-26.7%	-29.3%
Non-Teaching	4177	-7.8%	-7.7%	-7.9%	-10.9%	-13.3%	-15.7%	-18.4%	-23.0%	-25.7%	-28.5%
Type of Hospital											
Urban	2914	-3.1%	-4.5%	-4.6%	-6.1%	-10.4%	-15.1%	-17.7%	-24.2%	-26.7%	-29.3%
Large Urban	1545	-1.9%	-3.6%	-3.5%	-4.5%	-9.2%	-14.5%	-17.1%	-24.1%	-26.5%	-29.0%
Other Urban	1369	-4.9%	-6.0%	-6.2%	-8.5%	-12.2%	-16.0%	-18.6%	-24.4%	-27.0%	-29.7%
Rural	2271	-4.2%	-0.7%	-0.8%	-8.5%	-10.2%	-13.1%	-16.1%	-20.3%	-23.3%	-26.4%
Sole Community	541	1.0%	1.6%	1.6%	-9.8%	-9.9%	-12.6%	-15.7%	-20.5%	-23.5%	-26.6%
Sole Comm and Rural Referral	46	4.1%	9.4%	9.4%	-2.1%	-5.0%	-7.5%	-10.2%	-14.4%	-17.1%	-19.9%
Rural Referral	188	-5.9%	-3.1%	-3.0%	-9.1%	-12.6%	-15.8%	-18.7%	-23.6%	-26.5%	-29.3%
Other Rural	1496	-6.4%	-1.7%	-1.8%	-8.8%	-9.5%	-12.3%	-15.6%	-19.1%	-22.2%	-25.4%
Payment Adjustments											
IME & Disp Share	483	4.1%	2.8%	3.2%	1.9%	-3.8%	-10.8%	-13.4%	-24.6%	-26.8%	-29.0%
IME Only	774	-5.0%	-5.5%	-6.3%	-8.5%	-11.1%	-13.6%	-16.5%	-24.6%	-27.4%	-30.2%
Disp Share Only	383	-4.0%	-5.4%	-5.5%	-8.1%	-13.1%	-18.6%	-21.3%	-23.9%	-26.4%	-29.0%
None	3545	-6.9%	-7.0%	-7.1%	-10.0%	-12.9%	-15.9%	-18.5%	-22.9%	-25.7%	-28.4%
Medicare Proportion of Rev.											
Over 60%	1175	-6.6%	-7.2%	-7.4%	-11.2%	-14.1%	-17.1%	-20.1%	-23.2%	-26.0%	-28.8%
Under 60%	4010	-2.7%	-3.5%	-3.6%	-5.7%	-9.8%	-14.5%	-17.1%	-23.8%	-26.3%	-28.9%
Size											
1-50 Beds	1362	-4.5%	-2.1%	-2.4%	-9.3%	-10.3%	-13.3%	-16.4%	-18.6%	-21.8%	-25.1%
50-99 Beds	1123	-6.0%	-4.7%	-5.0%	-10.1%	-11.8%	-14.7%	-17.9%	-21.3%	-24.3%	-27.5%
100-199 Beds	1226	-5.8%	-5.5%	-5.8%	-9.0%	-11.8%	-14.7%	-17.6%	-23.5%	-26.3%	-29.2%
200-299 Beds	670	-5.6%	-6.3%	-6.5%	-8.7%	-12.3%	-15.8%	-18.6%	-24.6%	-27.2%	-29.9%
300+ Beds	804	-1.0%	-2.5%	-2.5%	-4.0%	-8.9%	-14.6%	-17.0%	-24.0%	-26.3%	-28.7%
Ownership											
Church	674	-3.9%	-4.9%	-5.2%	-7.0%	-10.4%	-13.8%	-16.3%	-21.5%	-23.9%	-26.4%
Voluntary	2327	-2.9%	-3.8%	-3.8%	-6.4%	-10.9%	-16.0%	-18.8%	-25.1%	-27.7%	-30.4%
Proprietary	748	-5.6%	-6.5%	-6.4%	-7.4%	-9.7%	-12.0%	-13.9%	-18.3%	-20.6%	-23.0%
Government	1436	-1.6%	-1.6%	1.6%	4.8%	8.9%	-14.2%	-17.0%	-26.4%	-29.3%	-32.2%
Alabama	116	-2.5%	3.3%	3.3%	5.6%	8.3%	-11.3%	-13.2%	16.9%	19.3%	-21.8%
Alaska	16	-1.4%	-2.6%	-2.7%	-13.4%	-14.7%	-16.5%	-18.4%	-25.7%	-28.3%	-31.0%

* Actual

Table 4:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by State Under the Health Security Act

			Pre OBRA 93			OBRA 93	Health Security Act					
		N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State												
	Arizona	57	1.2%	0.4%	0.5%	-0.7%	-3.3%	-5.9%	-7.2%	-11.0%	-12.8%	-14.6%
	Arkansas	81	-0.1%	-1.5%	-1.9%	-8.3%	-11.1%	-14.1%	-16.8%	-19.8%	-22.7%	-25.7%
	California	437	-0.1%	-2.4%	-2.4%	-2.4%	-5.4%	-8.4%	-10.2%	-18.3%	-20.6%	-23.0%
	Colorado	67	-4.4%	-2.7%	-2.8%	-5.1%	-8.5%	-12.2%	-14.5%	-17.7%	-20.5%	-23.3%
	Connecticut	34	-11.8%	-15.1%	-14.6%	-16.3%	-23.7%	-32.3%	-37.0%	-42.4%	-46.1%	-49.8%
	Delaware	7	-12.0%	-12.4%	-12.0%	-14.8%	-19.2%	-24.7%	-26.8%	-28.8%	-31.2%	-33.6%
	Washington DC	9	-3.5%	-7.2%	-7.4%	-9.1%	-15.9%	-24.6%	-26.6%	-37.4%	-40.1%	-42.8%
	Florida	219	-9.2%	-10.3%	-9.7%	-10.3%	-12.7%	-14.8%	-16.3%	-20.1%	-22.1%	-24.2%
	Georgia	160	-7.8%	-6.6%	-6.8%	-9.6%	-12.9%	-16.5%	-19.0%	-25.6%	-28.5%	-31.5%
	Hawaii	20	-14.1%	-22.0%	-22.7%	-28.8%	-33.8%	-39.7%	-43.4%	-54.7%	-58.8%	-63.1%
	Idaho	42	-0.1%	3.2%	1.2%	-6.6%	-8.8%	-11.4%	-13.8%	-16.3%	-19.0%	-21.8%
	Illinois	204	-7.0%	-9.1%	-8.7%	-10.3%	-14.3%	-18.8%	-21.9%	-29.0%	-31.4%	-33.9%
	Indiana	116	-11.5%	-12.0%	-11.9%	-15.3%	-19.0%	-22.7%	-26.3%	-30.5%	-33.4%	-36.4%
	Iowa	123	-6.8%	-4.8%	-5.1%	-10.1%	-13.4%	-17.2%	-19.8%	-24.0%	-26.8%	-29.7%
	Kansas	131	-5.6%	-6.3%	-6.5%	-10.2%	-13.3%	-17.1%	-19.5%	-23.9%	-26.6%	-29.4%
	Kentucky	104	-4.2%	-5.3%	-5.2%	-8.1%	-10.6%	-13.5%	-15.6%	-21.4%	-23.8%	-26.2%
	Louisiana	138	-11.2%	-11.6%	-11.3%	-11.5%	-14.1%	-16.9%	-18.9%	-25.5%	-27.8%	-30.3%
	Maine	39	-9.0%	-13.1%	-13.6%	-16.1%	-20.1%	-24.7%	-29.2%	-36.5%	-40.1%	-43.7%
	Maryland **	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	Massachusetts	99	2.7%	1.3%	0.9%	-1.2%	-6.8%	-13.3%	-16.9%	-23.3%	-26.0%	-28.9%
	Michigan	171	1.1%	-1.2%	-0.8%	-3.6%	-8.2%	-13.8%	-17.0%	-22.8%	-25.1%	-27.4%
	Minnesota	149	2.8%	1.4%	0.4%	-3.5%	-8.6%	-14.7%	-17.6%	-21.1%	-24.3%	-27.6%
	Mississippi	104	-1.3%	-0.8%	-0.8%	-6.0%	-7.9%	-10.4%	-12.8%	-21.7%	-24.3%	-27.0%
	Missouri	132	-4.3%	-7.8%	-7.2%	-9.9%	-13.6%	-17.8%	-19.9%	-23.5%	-26.0%	-28.5%
	Montana	54	-0.9%	-0.2%	-0.2%	-8.5%	-10.2%	-12.3%	-14.6%	-17.6%	-20.3%	-23.1%

** Projections were not made for Maryland, which operates an all-payer rate setting system under a waiver from the Medicare program.

* Actual

Table 4:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by State Under the Health Security Act

			Pre OBRA 93			OBRA 93	Health Security Act					
		N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State												
	Nebraska	89	-14.6%	-13.0%	-13.3%	-12.3%	-15.5%	-19.4%	-21.6%	-26.8%	-29.5%	-32.3%
	Nevada	22	-4.6%	-4.8%	-4.1%	-3.5%	-4.8%	-5.8%	-6.8%	-9.4%	-11.4%	-13.4%
	New Hampshire	26	-18.5%	-16.6%	-16.3%	-13.5%	-17.6%	-21.9%	-25.6%	-28.4%	-31.2%	-34.0%
	New Jersey	88	-9.6%	-11.4%	-10.8%	-12.7%	-18.6%	-25.0%	-29.0%	-35.2%	-38.5%	-41.9%
	New Mexico	35	9.4%	9.4%	9.5%	3.7%	1.8%	-0.6%	-2.4%	-7.5%	-9.7%	-11.8%
	New York	218	7.8%	8.7%	8.5%	6.9%	1.0%	-6.4%	-10.3%	-22.4%	-24.5%	-26.8%
	North Carolina	126	-6.1%	-1.5%	-2.3%	-5.0%	-9.7%	-15.1%	-18.4%	-28.8%	-32.2%	-35.5%
	North Dakota	48	-4.5%	-1.8%	-1.3%	-6.7%	-8.4%	-10.5%	-12.2%	-14.0%	-15.9%	-18.0%
	Ohio	185	-6.5%	-6.7%	-6.7%	-11.3%	-15.9%	-21.0%	-24.4%	-29.4%	-32.0%	-34.6%
	Oklahoma	115	0.8%	-0.1%	0.0%	-6.9%	-9.9%	-13.2%	-15.7%	-20.7%	-23.5%	-26.4%
	Oregon	65	8.1%	4.1%	4.2%	-2.1%	-5.3%	-8.8%	-10.9%	-14.6%	-16.9%	-19.4%
	Pennsylvania	218	-2.4%	-3.0%	-2.9%	-4.9%	-9.6%	-15.1%	-17.5%	-23.5%	-26.0%	-28.7%
	Rhode Island	12	3.8%	1.9%	.4.9%	0.1%	-5.4%	-11.8%	-15.1%	-17.8%	-20.2%	-22.8%
	South Carolina	69	-13.9%	-9.3%	-9.6%	-11.6%	-15.5%	-19.7%	-22.7%	-33.2%	-36.0%	-38.9%
	South Dakota	53	-2.5%	-2.6%	-2.8%	-8.3%	-10.0%	-12.5%	-14.5%	-17.1%	-19.5%	-22.0%
	Tennessee	132	-6.9%	-10.6%	-10.4%	-12.4%	-15.3%	-18.6%	-20.7%	-19.1%	-21.6%	-24.1%
	Texas	398	-6.8%	-7.6%	-9.6%	-9.9%	-13.0%	-16.3%	-18.5%	-25.1%	-27.7%	-30.4%
	Utah	39	7.5%	9.2%	9.5%	5.4%	1.9%	-2.1%	-4.2%	-8.0%	-10.4%	-12.8%
	Vermont	15	-10.9%	-11.2%	-11.8%	-18.1%	-23.8%	-31.1%	-35.9%	-40.3%	-43.7%	-47.2%
	Virginia	99	-6.2%	-6.9%	-7.0%	-10.8%	-14.5%	-18.7%	-21.2%	-26.8%	-29.7%	-32.6%
	Washington	92	2.7%	2.3%	1.6%	-1.8%	-5.3%	-9.1%	-11.5%	-17.4%	-20.2%	-23.2%
	West Virginia	58	-7.1%	-5.4%	-5.4%	-14.1%	-18.0%	-22.4%	-25.4%	-32.0%	-35.2%	-38.5%
	Wisconsin	128	0.6%	0.8%	0.5%	-4.7%	-8.3%	-12.4%	-15.7%	-19.8%	-22.5%	-25.3%
	Wyoming	26	-1.8%	-12.6%	-10.7%	-23.7%	-25.3%	-28.3%	-30.7%	-32.3%	-35.4%	-38.6%

* Actual

KEY ASSUMPTIONS MADE BY LEWIN-VHI

- Medicare PPS inpatient operating margins are defined as Medicare inpatient operating revenue minus Medicare inpatient operating costs divided by Medicare inpatient operating revenue (R-C)/R.

- The following provisions of OBRA 1993 have an impact on hospitals and are included in the "OBRA 1993" portion of this analysis:
  - *Reductions in the PPS update factor*
  - *Changes in indirect medical education payments*
  - *Phase-out of day outlier payments*
  - *Hospital protection against certain changes in the wage index*
  - *Regional referral center extension*
  - *Small Medicare-dependent rural hospital payment extension*
  - *Regional floor extension*

- The following provisions proposed by the President would have a further impact on hospitals and are included in the "Medicare Reductions Under the Health Security Act" portion of this analysis:
  - *Reductions in the PPS update factor*
  - *Reductions in the indirect medical education adjustment*
  - *Reductions in disproportionate share hospital payments*

- Margin estimates reflect Medicare PPS inpatient operating revenues and costs only. Capital and other Medicare revenues (e.g., direct medical education) are not included. Margin estimates reflect the impact of the proposed Medicare spending reductions and do not reflect the impact of other provisions included in the Health Security Act.

- Hospital costs are assumed to grow by the rate of increase in the hospital market basket index plus 2.9 percentage points, or about 7.3 percent annually over the projection period. This rate of growth is about 1 percentage point less than historical rates of growth after adjusting for inflation.

- The Lewin-VHI model is a "static" model, so it does not include behavioral changes (e.g., changes in the organization of hospital service delivery) or changes in industry structure (e.g., no hospital closings or consolidations). This is because it is impossible to predict which types of hospitals may restructure, consolidate, or close. Moreover, little information is available to allow experts to model into the future how hospitals and the health care system generally might respond to the system-wide kinds of regulatory and market changes being proposed.

- The proposed change to an "all-payer" pool for indirect medical education costs is not included in the Medicare PPS margin estimates because non-Medicare funds (from regional and corporate alliances) would also be included in the pool, and would distort the Medicare PPS-only analysis. Medicare indirect medical education payments, reduced as specified by the Administration, are included and are assumed to continue until the year 2000.

- The Administration's proposal would significantly reduce Medicare disproportionate share payments as states form health care alliances. Because the timing of states' reform activities cannot be known, margin estimates assume that OBRA 1993 disproportionate share provisions continue in effect through 1997 and the disproportionate share provisions proposed by the Administration are fully implemented in 1998.

- No estimates were made for the state of Maryland because the state operates under a federal waiver and has a distinctive rate setting system.

NOTICE

This document is not available for public release until 10:00 a.m. Eastern time, Tuesday, April 12, 1994

MEDICARE REDUCTIONS:

UNFAIR TO EXPECT HOSPITALS TO DELIVER ON HEALTH CARE REFORM AND PAY FOR IT TOO

BACKGROUND:

Hospitals support comprehensive health care reform centered on three goals:

- Guaranteed coverage and access to care;
- More efficient and effective delivery of care; and
- Fair financing.

Hospitals understand that extending health coverage to the uninsured will take additional resources. We cannot, however, support unprecedented reductions in Medicare funding as a major source of these resources. Such reductions would be counter productive -- they would undermine our ability to achieve reform and threaten patient services.

For example, health care reform -- forming collaborative provider networks; reconfiguring hospitals and other services for the future -- will present major financial and organizational challenges for hospitals. It is unfair to expect hospitals to deliver on health care reform and pay for it too through deeper Medicare spending reductions.

Many of the congressional health care reform proposals would make unprecedented cut backs in the rate of increase in Medicare spending to pay for reform. The President's proposal would reduce Medicare spending by $118 billion over the next six years in order to finance health care reform. This is twice the size of any reductions previously taken from Medicare. Other proposals, including those offered by Representative Pete Stark (D-CA), Representative Jim Cooper (D-TN), and Senator John Chafee (R-RI) also would reduce Medicare spending by significantly more than ever before.

Outside the health care reform debate, many members of Congress favor limiting future spending on entitlement programs, including Medicare and Medicaid. Others support a requirement to balance the federal budget on an annual basis -- an approach that would hit hard on the largest federal programs, particularly Medicare.

Alternative sources of financing health care reform are available to spread the cost of reform more broadly, beyond hospitals, physicians, and other health care professionals who will already be deeply affected by change. For example, increasing alcohol and cigarette excise taxes ($86 billion), scaling back nuclear weapons production ($3 billion), and asking host nations to share in more of the cost of U.S. troops stationed abroad ($10 billion) would raise nearly $100 billion over five years toward health care reform financing.

STUDY FINDINGS:

New estimates prepared by Lewin-VHI look at the impact on hospitals of Medicare spending reductions. It is important to note that these estimates do not pretend to predict the future with any certainty -- they are highly sensitive to underlying assumptions about future growth in hospital costs. However, these estimates are illustrative of the kinds of pressures that hospitals face if Medicare spending reductions alone of this magnitude are enacted.

The Prospective Payment Assessment Commission (ProPAC) has already concluded that today. payments to hospitals under Medicare's Prospective Payment System do not keep pace with hospitals' costs. The new Lewin-VHI estimates confirm that this pattern will likely continue.

The study uses the President's plan -- the most detailed available -- as an example. Among the health care providers and Medicare beneficiaries who would be affected by the President's Medicare spending reductions, administration estimates show that hospitals are hardest hit, taking $70 billion of the $118 billion in proposed reductions.

Data show that reductions like these, with no accompanying reform steps such as expanding health care coverage, could cause significant financial losses for hospitals. Losses might be attenuated by reducing the rate of growth in hospital costs. But hospitals are concerned that losses of this size can not be made up through increased efficiency. Medicare reductions could undermine hospitals' ability to transform and improve the health care system for patients and threaten their ability to continue to deliver quality care in the communities they serve.

The Lewin-VHI data show:

- By the year 2000, after six years of spending reductions, **Medicare could pay hospitals only 71 cents for every dollar of inpatient care delivered to a Medicare patient.** The overall Medicare Prospective Payment System (PPS) inpatient operating margins for all hospitals in the U.S. could be *negative* 29 percent (see table 3).

- These spending reductions could **make the Medicare program an even poorer payer than the Medicaid program is today**, which currently pays hospitals 82 cents on the dollar.

- **Coping with the spending reductions already enacted in the Omnibus Budget Reconciliation Act (OBRA 1993) will be difficult enough for hospitals.** Lewin-VHI data show that by the year 2000, the overall Medicare PPS inpatient operating margin for all hospitals in the U.S. would be *negative* 12 percent as a result of changes enacted in OBRA 1993 (see table 1). The additional reductions proposed by the President could lower this margin by an additional 17 percentage points (see table 3).

- **Particularly hard hit are teaching hospitals, hospitals in large urban areas, and hospitals serving a disproportionately large number of low-income patients.** By the year 2000, Medicare PPS inpatient operating margins could be reduced by 22 percentage points for teaching hospitals; reduced by 19 percentage points for large urban hospitals; and reduced by 26 percentage points for hospitals receiving both indirect medical education and disproportionate share adjustments.

- **After six years, regardless of hospital type -- large or small, urban or rural, teaching or non-teaching -- most hospitals face significant Medicare losses.** Under current law, Medicare PPS inpatient operating margins for various types of hospitals are expected to average between positive 4 percent and a negative 18.5 percent (see table 1). If the President's reductions were enacted, Lewin-VHI data suggest these margins could average between a negative 19.9 percent and a negative 32.2 percent (see table 3).

- **All states are negatively affected.** After the enactment of OBRA 1993, hospital margins varied considerably by state (see table 2). But Lewin-VHI data show that if the Medicare reductions proposed by the President are enacted, all states would lose significant shares of revenue, driving Medicare PPS inpatient operating margins down (see table 4).

IMPLICATIONS:

Medicare spending reductions have serious implications for the future of health care reform, hospitals, patients, and communities.

Hospitals may be without the resources needed to achieve comprehensive reform -- to reconfigure the way in which they deliver care to be more efficient and to refocus on the health of the patients and communities they serve.

Cuts will be felt by hospitals, patients, and communities more deeply than ever before. In the past, hospitals have been able to shift unfunded costs to other non-government payers, meaning higher costs for patients and employers. But this avenue will be narrowed, if not closed, by the current rapid growth in managed care in the private sector as well as by many of the comprehensive health care reform proposals that propose to limit private sector spending. Thus, hospitals will have to cut costs which could mean personnel and service cutbacks.

Some communities may see their hospitals close for the wrong reasons -- not because they are no longer needed, but because they are financially weak. The kinds of Medicare spending reductions proposed hit hardest on the most financially vulnerable hospitals -- those barely breaking even or already operating at a loss and those that treat large numbers of Medicare beneficiaries. These hospitals may be the very ones that need to remain open to assure access and coverage to underserved populations and achieve the broader goals of health care reform.

PREPARED STATEMENT HON. DAVE DURENBERGER

Mr. Chairman, the President told us that he wanted to assure six things with health reform: *Security, simplicity, savings, choice, quality, and responsibility.*

I believe we will pass a health care bill this year, and meet the President's goals. We must meet these goals, however, without creating cumbersome bureaucracies, Federal or state government regulatory schemes, or price controls. I believe we will meet those goals by changing the market incentives. The reform must allow markets to do what only markets can do—increase efficiency, lower costs, and improve quality. And, the bill must not leave the Medicare program out.

Mr. Chairman, none of the health reform proposals bring these essential elements of health reform to America's seniors and disabled. Every health care reform plan, including the two I am sponsoring, have failed to address the underlying cost and access problems and they do not integrate seniors and the disabled into a 21st century health care system.

I believe they deserve better. They *certainly* deserve the same benefits as everyone else. And, the seniors in Minnesota know this. A few weeks ago, I received a letter from one of my constituents, Mr. Howard Huelster of St. Paul, Minnesota. He wrote, "I am shocked and offended by the huge discrepancies between Medicare's payments to Minnesota seniors compared to payments to seniors in Florida, California and New York." Mr. Huelster goes on to say, "While I know it would be unfair to ask for the same high payment that Florida's seniors get, it would be fair to ask for all seniors in all states to receive the same payment! This might well force the inefficient health care providers in other states to become as efficient as Minnesota health care providers." It's for these reasons and seniors like Mr. Huelster, that I introduced the Medicare Choice Act.

This Committee has a long history with giving Medicare beneficiaries the ability to choose managed health care. The Senate Finance Committee invented the current payment formula, soon after the Medicare program was created. The current formula was created to prevent HMOs from "cream skimming." HMOs, however, have, since then, grown sufficiently to be major providers in many markets—therefore, their ability to cream skim has diminished.

It is now time to reform the payment formula to take advantage of the cost-saving opportunities in the current health care market. Fortunately, the experience of this Committee will allow us fix the payment formula to give beneficiaries real choice among providers of Medicare benefits.

While serving on this Committee, I have recognized the need to restructure the Medicare program to fulfill the promise of true health care security for the elderly and disabled. In the 99th and 100th Congresses, I introduced the "Medicare Voucher Act of 1986" and the "Medicare Private Health Plan Capitation Improvement Act of 1987" to allow Medicare beneficiaries the full range of health care options avail-

able to the rest of the population: The goals of these bills were identical to the goals of the "Medicare Choice Act of 1994."

We planted the seeds for the Medicare Choice Act in 1982 when we created TEFRA risk contracts. These contracts allowed seniors to choose more benefits, at a lower cost and with less paperwork, through Health Maintenance Organizations (HMOs). Unfortunately, we tied federal HMO payments too tightly to the flawed Medicare fee-for-service payment scheme. HMOs, therefore, never liked the project, and now participate in only a few parts of the country.

To address the flawed payment system and to increase the number of plans and beneficiaries choosing to receive care through cost-effective, managed-care plans, the Medicare Choice Act creates a new payment methodology. The new payment scheme allows managed-care plans to bid to serve Medicare beneficiaries, and pays all the plans in an area the same rate based on the lower bids. Thus, managed-care plans can determine the premium they need to serve seniors and the disabled, and compete in the open market to attract medicare beneficiaries.

With people choosing between plans based on cost and quality, the plans will strive, as any competitor does, to provide the best services at the lowest cost. This is our best hope for getting Medicare costs under control without reducing quality or services that result from squeezing money out of Medicare.

The Medicare Choice Act also allows retirees to stay with their employers' plan. I have often wondered why retirees should not receive health care at age 65 just as they received it at age 64. Under this bill, one of the options seniors can choose will be to continue in their former employer's health plan, as long as it provides Medicare benefits. Under this provision, the only change at age 65 is the Federal contribution toward the plan's premium.

The Medicare Choice Act will also place responsibility where it belongs. Health plans will be responsible for maintaining the health of their members and using the best medicine efficiently in order to compete. The Federal Government will finally live up to its responsibility to provide the financial security that was the original intent of Medicare. No one will be surreptitiously and irresponsibly shifting costs from the Federal Government to other payers.

Mr. Chairman, there are many details that we need to work out in health care reform. I am excited by the progress see that we are making every day. I believe we can accomplish great things this year in health reform.

We can do it, and we will. And when we do, I want to include older Americans and Americans with disabilities in health care reform. The Medicare Choice Act begins this process.

PREPARED STATEMENT OF CHARLES P. DUVALL

Mr. Chairman and Members of the Subcommittee:

My name is Charles P. Duvall, MD. I am an internist and clinical oncologist from Washington, DC. I am a Clinical Professor of Medicine at Georgetown University, and I am a member of the American Medical Association's (AMA) Council on Legislation. Accompanying me is Bruce Blehart, JD, Director of the AMA's Division of Federal Legislation. On behalf of the AMA, I am pleased to have this opportunity to testify regarding directions for the Medicare program in a reformed American health care system.

In our appearance today, and indeed in all of our considerations on the myriad issues that are encompassed within health system reform, medicine continues to focus on our traditional and paramount concerns—expanded access to high quality, affordable care for all of our patients. For our elderly and disabled patients, the Medicare program demonstrates that these concerns can be addressed. With the Committee, the Congress and the entire country coming to grips with the very issues that Medicare resolves for the elderly and the disabled, there is an underlying question: how will health system reform affect the Medicare program and its more than 30 million beneficiaries? From our perspective, there is a tremendous positive potential to provide Medicare beneficiaries greater choice in health care coverage options; there also is a serious threat to Medicare beneficiaries if program cuts are enacted that are anywhere near the magnitude proposed under the Health Security Act, S. 1757.

The Health Security Act holds out the promise of increased opportunities for future Medicare beneficiaries as well as current beneficiaries to receive care through the private sector alliance based health plans and through employment-based plans. However, there is no certainty that any of these potential coverage mechanisms would be better, or even as good as, the current Medicare program, and this certainly would not be in keeping with the promise of the Medicare program.

The AMA has further concerns that the proposed budget driven program changes would result in program deterioration. These proposals would undermine the fundamentals of 1989 legislation that set into motion Medicare physician payment reform, including the resource-based relative value scale (RBRVS). This Committee, and Senators Durenberger and Rockefeller in particular, had a vital role in the development of physician payment reform, and we are pleased that you also will have an essential role in crafting health system reform. We are pleased that you will be addressing the proposed Medicare program cuts that we believe threaten access for Medicare beneficiaries. These further massive cuts send exactly the wrong signals about the degree to which physicians and other Americans can expect their government to honor commitments made as part of health system reform.

MEDICARE'S ROLE UNDER HEALTH SYSTEM REFORM

The health system reform bills under your consideration address the future of Medicare in some detail. The AMA supports the major Medicare principles of S. 1757, S. 1770, and S. 1579 in their shared recognition that Medicare is a unique health care coverage program that must be preserved. The AMA strongly supports the Clinton Administration's position, as recently underscored by HHS Secretary Donna E. Shalala, that it will be necessary to "preserve Medicare" as part of any health system reform package. In maintaining Medicare, we think that beneficiaries also should have enhanced coverage options through the private sector.

As you know, the Health Subcommittee of the House Ways and Means Committee has reported a proposal to use a new Medicare Part C as the vehicle to provide coverage for those without coverage, the unemployed, and for small business. While the AMA endorses the Subcommittee's directions that would result in universal coverage, we do not support the vast expansion of Medicare envisioned in the proposal. Rather than create a massive and expensive new entitlement program under a new Medicare Part C, the AMA believes a better approach would be to expand coverage for other targeted groups, such as the uninsured, through private sector reforms, including insurance reform, use of risk pools, and integration of Medicaid and uninsured populations into private plans through the use of subsidies. (The subsidy/integration direction is similar to the Administration's approach under S. 1757.) We also support improved Medicaid payment to levels at least on par with Medicare.

Greater options could also be made available to the current Medicare population so that individuals would have the ability to choose the plan, public or private, that best meets their needs. Our Council on Legislation is scheduled to examine Senator Durenberger's recently introduced proposal, S. 1996, that we think holds promise for allowing Medicare beneficiaries greater choices for their health care coverage.

PROPOSED MEDICARE CUTS

In 1989, physicians entered into an agreement with Congress and the Administration when Medicare physician payment reform was enacted. With the Administration and most Members of Congress asking physicians and all of our society to enter into an even more comprehensive and far reaching social compact to reform the entire health care system, we are dismayed that an integral part of the Administration's health system reform plan as well as other proposals abrogate many of the very agreements over payment reform that were achieved with such difficulty and solemnity five years ago and that are now just completing the phase-in period.

In considering further Medicare program cuts, it must be remembered that they would fall on top of a decade of significant program cuts and that all of the OBRA 93 budget actions have yet to occur. Of the $124 billion in overall Medicare savings that would be achieved through the series of policy changes specified in S. 1757, savings related to Medicare Part B would amount to $31.5 billion through 2000. It bears noting that virtually none of the Administration's proposals for Medicare program cuts are even mentioned in the Congressional Budget Office (CBO) March 1994 report, *Reducing the Deficit: Spending and Revenue Options.* Furthermore, the need from a budget deficit viewpoint for this magnitude of program cuts is questionable when we can see that the rate of program growth is diminishing. The amount Medicare pays for services is also diminishing when compared to private sector payments. According to the Physician Payment Review Commission's (PPRC) just released report, where Medicare paid 68% of the average amounts paid by Blue Cross Blue Shield and Commercial insurers in 1989, this figure has gone down to 59% in 1994.

Looking at a number of the proposals from S. 1757 together, they can only be seen as instituting an unwarranted overhaul of the Medicare physician payment schedule that is based on the RBRVS, and is the basis of over one fourth of all physician payments. These proposals undermine the fundamentals of physician payment re-

form and threaten access for Medicare beneficiaries. They inject instability and complexity into a system instituted to provide just the opposite. They reflect a seeming and unseemly cynicism about physicians as "deep pockets" from which both deficit reduction and health system reform can be funded. They promise to dramatically accelerate a downward spiral of Medicare physician payments. With the PPRC telling us that Medicare pays 59% of what private payments run for the same service (even though an older or disabled patient often will require more time in providing the care), the pressures for cost shifting are evident and will be even stronger if these proposals are enacted. It only stands to reason that we have such strong and profound concerns about the broader implications of these cuts.

Taken together, the proposals to establish cumulative expenditure goals for physician services, use real Gross Domestic Product (GDP) to adjust for volume and intensity, eliminate even the limited level of balance billing, repeal the restriction on the maximum reduction permitted in the default update, and limit payment for physicians' services in so-called high-cost hospital medical staffs, will almost certainly send Medicare physician payments and spending on needed services into a tailspin from which they will never recover, and will exacerbate cost shifting and other pressures. The attached table illustrates this point.

The AMA also finds a series of proposals that would "overhaul" the RBRVS to be particularly inappropriate. The proposals (modification of Medicare payment for office consultations, revisions to the RBRVS practice expense values, payment adjustments for office visit work RVUs, and reductions in the work RVUs for those services identified as having high ratios of work RVUs per procedure time) generally would manipulate the RBRVS to reach the predetermined outcome of a substantial increase in the Medicare payments for designated primary care services. The AMA is committed to an RBRVS that is based on accurate measures of physicians' resource costs, and these proposals fail this measure. The RBRVS should be based on, and only on, accurate measures of physicians' resource costs; it should not be revised solely to achieve inter-specialty payment goals. Relative value adjustments outside of the normal refinement processes, solely to achieve inter-specialty payment redistributions, threaten the RBRVS and its continued viability, especially for use beyond Medicare.

Our detailed discussion on the Medicare Part B proposals set out in S. 1757 are attached to this statement as an appendix. These issues were under public scrutiny at the end of last year, and we still concur with the points expressed in a November 4, 1993 bipartisan letter to the President from forty-one (41) Members of the House of Representatives:

> "Medicare and Medicaid savings of the magnitude that are contemplated in your proposal, coupled with those already enacted as part of the OBRA 93 and OBRA 90, will continue to push many health care providers toward the brink of financial disaster and risk eroding access to care for millions of poor, elderly and disabled Americans. It is unclear whether the rigid, formula-driven budget caps that your proposal would impose on the Medicare and Medicaid programs bear any relation to the actual health needs of a community, or if they will be flexible enough to respond to changing and unforeseen circumstances."

Even though a substantial amount of savings would be attained from these proposals, we are concerned that this would be achieved at far too great a human cost. As further stated in the Representatives' November 4 letter:

> " . . . the level of reductions you have suggested in your proposal may place these important programs for the poor, elderly and disabled in severe financial jeopardy."

CONCLUSION

In conclusion, we want to leave you with the clear understanding that the American Medical Association staunchly supports actions to reform our nation's health care system. However, this restructuring should be done in a manner that builds on what works in the existing system. Medicare beneficiaries should have enhanced options beyond government structured health care coverage. Proposals that essentially will eviscerate the Medicare program as a means to fund other aspects of health care delivery fails this litmus test and only exacerbates the cost shift problem that is one of the central rationales for reform. It makes little sense to finance care for one segment of the population by stripping funding from Medicare. Positive steps should be tried, such as means testing for higher income patients and other reasonable measures such as allowing managed care options and voluntary enrollment in purchasing co-ops for beneficiaries. Finally, the AMA will continue to support the ability of our patients, including Medicare beneficiaries, to have free choice of coverage options and access to health care services of the highest quality.

MEDICARE PROPOSALS FROM S. 1757, "THE HEALTH CARE SECURITY ACT" VIEWS OF THE AMERICAN MEDICAL ASSOCIATION

ESTABLISHMENT OF CUMULATIVE EXPENDITURE GOALS FOR PHYSICIAN SERVICES

Using fiscal year 1994 as a base, this provision would compare the two factors of cumulative Medicare Volume Performance Standards (MVPSs) and cumulative actual expenditure increases to determine the annual default conversion factor update. The conversion factor update for a category of physicians's services for a year beginning with 1996 would increase or decrease by the percentage by which the cumulative increase in actual expenditures for that category of physicians' services for that year was less than or greater than the MVPS for that category of services for that year.

Preliminary simulations of this proposal demonstrate that the cumulative MVPS will almost certainly send Medicare physician payments into a tailspin from which they will never recover. This new "update" process would be compounded by the proposal to substitute real Gross Domestic Product (GDP) for the real data on historical medical volume and intensity, and the proposed elimination of any floor on payment reductions. With expenditures highly likely to come in over the target in future years, fees probably would be reduced each year and there would be no limit on this reduction. The penalty for exceeding the MVPS compounds each year, and the concept of individual physician responsibility for the volume and intensity of services become irrelevant in the confusion.

Discussions with staff from the PPRC and the HCFA Office of the Actuary suggest that one of the worst features of this provision, which would impose a double penalty on physicians for years in which expenditures exceed the MVPS, is likely to be subject to a technical correction. Nonetheless, the PPRC has also concluded that the cumulative MVPS should not be used if the other MVPS tightening provisions of S. 1757 are enacted. We certainly agree, but also feel that the current MVPS structure, as modified by OBRA 93, is likely to lead to the same kind of persistent mismatches between expenditures and the MVPS that will be aggravated by the cumulative MVPS. We continue to oppose the cumulative MVPS, even if revised to eliminate the double penalty and even if other proposed MVPS cuts are scaled back. Under this proposal, the gap between Medicare and private payments is certain to continue its current downward trend. According to the Physician Payment Review Commission's (PPRC) just released report, where Medicare paid 68% of what an average of Blue Cross Blue Shield and Commercial insurers paid in 1989, this figure has gone down to 59% in 1994.

USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY

The Clinton proposal would eliminate the historical medical volume and intensity factor (and the performance standard) from the MVPS and replace it with the average per capita growth in the real GDP for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for primary care services). While we do appreciate the improvement this represents over the September 7 draft, that proposed elimination of this factor entirely, this will only serve to further drive down updates. In general, growth in real GDP per capita has been far below historical levels of medical volume and intensity growth. For 1986-1992, the average annual growth in real GDP was 2.30% while the average growth in real volume and intensity (as measured by the Medicare Trustees) was 6.94%. The PPRC has projected that the current volume and intensity allowance will be 2 to 2.5 percentage points above real GDP.

This proposal improperly assumes that the appropriate rate of growth for health care expenditures is GDP. This presumption flies in the face of the fact that the provision of health and medical care occurs in a highly service intensive sector of our economy, similar to the education sector, where the labor and the costs of services historically exceed the costs of goods. And, in truth, the costs associated with providing this care also should not be unexpected. These costs historically have risen at a rate above the rate of growth in the GDP, the consumer price index, and other economic measures. Furthermore, the technology intensive nature of health care today and in the future acts as an accelerant and is a further significant reason why there is the gap between real GDP and real medical volume and intensity. This gap also represents a real demand for the services from which our patients benefit.

Nevertheless, the proposal arbitrarily would limit program growth leading to spending increases far below even nominal GDP growth. This proposal is unacceptable, as it would eliminate any remaining shred of credibility for the MVPS as a reasonable guideline for the evaluation of spending on physician services.

REPEAL OF RESTRICTION ON MAXIMUM REDUCTION PERMITTED IN DEFAULT UPDATE

The floor on MVPS payment reductions was an integral part of the OBRA 89 compromise. It served to protect physicians and patients from excessive and automatic application of the MVPS formula. Nevertheless, OBRA 93 just three months ago increased the maximum MVPS-related payment reduction from 3% to 5%. This change has already eroded the floor on MVPS-related adjustments that was an integral part of the OBRA 89 agreement. By the outright elimination of this floor, the other changes set out in the Administration's proposal would combine to wreak maximum havoc on physician payment reform.

REDUCTION IN CONVERSION FACTOR FOR PHYSICIAN FEE SCHEDULE FOR 1995

Following on OBRA 93 reductions in the 1995 conversion factor, S. 1757 proposes even steeper reductions in the conversion factor update for non-primary care services in 1995. It would allow the full 1995 default update only for primary care services and would reduce the 1995 conversion factor update by 3 percentage points for all other services.

Given that all indications are that 1993 actual Part B physicians spending will be well below the 1993 MVPS, especially for surgical services, it appears that this proposal will once again prevent physicians from realizing promised payment increases. This provision further abrogates the agreement that created the MVPS, and would be added on top of cuts already scheduled for 1995 that were enacted in OBRA 93. This provision would be little more than a jump start to a future of diminishing real payments for services provided Medicare beneficiaries.

LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES IN HIGH-COST HOSPITAL MEDICAL STAFFS

The Plan would create an elaborate scheme of hospital medical staff MVPSs. In general, this provision would require the Secretary of HHS to project a hospital-specific per admission relative value for the next year by October 1 of each year (beginning with 1997) for each hospital and to estimate whether or not this hospital-specific projected relative value will exceed the allowable

average per admission relative value applicable to the hospital for the following year. The allowable average per admission relative value is set as a percentage of the median 1996 hospital-specific per admission relative value and is set differently for urban (120% for 2000 and beyond) and rural (140%) hospitals. It would be adjusted for case-mix, disproportionate share, and teaching status. If any overage is projected, the Secretary would reduce all payments made for hospital inpatient services provided by physicians on that medical staff by 15%.

The AMA is very concerned by the many negative implications of this proposal. It would:

- create a new and onerous regulatory structure that would be based on non-existent data, and that would not account for severity and case mix;
- require the Secretary to project hospital-level average relative values per admission and, based on these projections, would withhold the full 15% of all payments for medical care even if the projected overage is 1% or even .1% (The MVPS experience shows the limit of the nascent "science" of volume/intensity projections.);
- delay reconciliation until October 1 of the following year, even though relevant data would be available by April 1;
- establish specific standards for "high cost" medical staffs in advance of any provisions for public notice and comment;
- assume that DRG-based case mix adjustments were appropriate for physician payments;
- require medical staffs to establish expensive fiscal and administrative structures to monitor care using measures that may not be appropriate for such a purpose; and
- violate agreements on MVPS-structure that were made as a result of OBRA 93.

Finally, this proposal would shift both hospital and physician payment incentives to reward the provision of the least care. Physicians as well as other care givers should not be penalized for advocating care for their patients. This certainly violates the principles of security, responsibility, quality and choice.

ELIMINATION OF MEDICARE BALANCE BILLING

The Administration proposes to impose mandatory assignment on all Medicare Part B claims as of January 1, 1996. The AMA strongly protests this change, except for those with incomes less than 200% of poverty. Again, this is a major violation of the agreements reached in reforming physician payments under Medicare in 1989. This also is inconsistent with the Physician Payment Review Commission's (PPRC) annual recommendations to the Congress. This change would exacerbate current cost shifting pressures. Also, as previously noted, this type of action will increase Part B spending as patient out-of-pocket costs are reduced. Particularly with Medicare payment levels continuing to shrink in comparison to the private sector (now at 59%), there is a legitimate role for balance billing. Finally, it must be noted that this represents a small portion of beneficiary liability and that assignment is accepted on the vast majority of claims. According to the AARP's *Issue Brief*

(March 1994, Number 17), balance billing was responsible for 9% of total out of pocket liabilities for Part B by source in 1990 (other factors: deductibles - 9%; coinsurance - 39%; and premiums - 43%). The AARP also noted that declines in balance bills are expected to continue.

RBRVS OVERHAUL

Section 4115 of the Plan, titled Medicare Incentives for Physicians to Provide Primary Care, proposes what can only be referred to as an "RBRVS overhaul." This provision addresses:

- Medicare payment for office consultations;
- payment for office visit work and practice expense relative value units (RVUs);
- resource-based RBRVS practice expense values; and
- payment for services with high ratios of work RVUs/time.

In general, these proposals manipulate the RBRVS to reach a predetermined outcome—a substantial increase in the Medicare payment levels for primary care services. (Under current law, primary care services include office visits, emergency department services, and several other categories of visits; they do not include consultations, hospital visits, or critical care.)

The AMA is committed to an RBRVS that is based on accurate measures of physicians' resource costs. We have made a major commitment to organize physician groups into a Relative Value Update Committee (RUC) in order to maintain the RBRVS's scientific validity. HCFA already relies on the RUC results in the RBRVS update process. (We would be pleased to provide further information on this activity for the Committee and its staff.)

The RBRVS should be based on, and only on, accurate measures of physicians' resource costs. RVUs should not be revised solely to achieve inter-specialty payment goals. Relative value adjustments outside of the normal RUC and refinement processes, solely to achieve inter-specialty payment redistributions, threaten the RBRVS and its continued viability, especially for use beyond Medicare. Finally, the AMA continues to have concerns about funding specific policy changes by reducing RBRVS RVUs. We continue to favor a separate Medicare Adjustment Factor to make such budget neutrality adjustments. A separate Medicare adjustment factor would recognize budget neutrality needs, avoid distortions to the RVUs, and avoid allowing Medicare budget constraints to drive non-Medicare RBRVS systems.

Resource-Based Practice Expenses - This proposal calls for the Secretary of HHS to increase practice expense (PE) RVUs for primary care services by 10% starting in 1996, with RVUs reduced for all other services by a budget neutral amount. It also calls on the Secretary to establish a resource-based PE method that could be implemented in 1997 and to report to Congress by June 30, 1996, on the methodology for this system, including a presentation of the data utilized in developing the methodology and an explanation of the methodology.

The AMA continues to support a PE study by the HHS Secretary. Prior to completion of the RBRVS transition in 1996 and without the results of this study, we oppose implementation of resource-based practice expense RVUs. Although a 10% increase in the primary care practice expense RVUs would

be consistent with current projections of the PPRC's resource-based practice expense method, it would result in payment reductions for all other services regardless of whether the PE RVUs would increase or stay unchanged under the ultimate RBRVS PE methods. This proposal, on top of the just enacted OBRA 93 updates that favor primary care services, is premature.

Office Consultations - This proposal would cut Medicare payment rates for office consultations to equal those for office visits beginning in 1996. It would use resulting savings to increase payments for office visits. Under this proposal and based on 1993 national (no geographic adjustment) RBRVS amounts, it would be possible that payments for new patient office visits would increase by 5.5% and payments for office consultations would decrease by 23-31%. Medicare payments to specialties providing a substantial share of primary care services would rise—family physicians (2.1%), internists (.2%) and allergists (1.3%). Payments to other specialists, including cardiologists (-1.3%), gastroenterologists (-2.3%), and neurologists (-6.5%), would fall.

This provision would make large cuts in current consultation payments to fund small office visit increases, and it would be contrary to PPRC conclusions that consultations should have higher average work intensities.

Office Visit Work RVUs - This proposal would increase office visit work RVUs by 10% to reflect "office visit pre- and post-time." The RVUs for all other services would be reduced to fund this change, as with the PE RVU increase. The assumption is that all pre/post-service time is not included in the current RBRVS values. We are concerned that the methodological or data basis for this change is unclear. Furthermore, this provision would have a significant negative effect, and that this consequence also would fall on some specialties usually thought of as providing primary care. Our impact projections forecast that the combined effect of the provision and the 10% increase in primary care PE RVUs would require a 2.3% decrease for all other services. Combined impact projections show a 3.8% increase for family practice, a 1.9% increase for internal medicine, a 0.9% decrease for general surgery, and a 2.3% decrease for radiology.

Reduce the Work RVUs of "Outlier Intensity" Procedures - Beginning in 1996, this proposal would require the Secretary to reduce the work RVUs for "outlier intensity" procedures, or classes of procedures, that have a high ratio of work RVUs per procedure time. "Savings" would be used to increase payments for primary care services. This proposal resembles the approach in OBRA 93 to reduce "outlier" PE RVUs. No specific threshold or level of reduction is suggested, nor is there a publicly available database with this information.

This proposal would simply assume that "outlier" intra-work RVUs are inappropriate, even though they were developed by the same Harvard RBRVS method used for the overall RBRVS and have not been altered by HCFA's refinement process. The AMA opposes such an arbitrary series of reductions outside a formal RVS update and refinement process. The RUC currently is working on methods that could be used to identify overvalued services. This proposal could distort the relative values for both outlier services and primary care services. It could also set a precedent for non budget-neutral reductions for other categories of "overvalued" services.

COMPETITIVE BIDDING

The "Health Security Act" calls for the use of competitive bidding as a mechanism to pay for various health and medical services. In addition to broad authority to determine what would be purchased

through competitive bidding, the proposal specifically calls for this method to be used as the payment mechanism for MRI and CT scans (including physician interpretation), and clinical diagnostic laboratory services. If competitive bidding does not result in a 10% reduction in the fee schedule for clinical laboratory services, the Secretary would be required to reduce such fees to achieve the 10% reduction.

While competitive bidding may be appropriate as a purchasing mechanism for goods and services where quality is readily discerned or generally does not vary, it is wholly inappropriate for the purchase of professional services that are tailored to dynamic and highly individual needs. Competitive bidding is a particularly inappropriate mechanism to purchase medical and health care services, and it violates the principles of security, responsibility, quality and choice.

Where items are standardized or easily specified, such as nuts and bolts, competitive bidding is a logical mechanism for choosing the supplier of goods. However, where professional services are being purchased, even what appears to be a "standardized" service may not be so easy to quantify.

Competitive bidding may result in a reduction in the quality of and access to the service sought. The potential for reduced quality is particularly real in the health care sector of the economy where the services are unique due to many variables, including the involvement of individual patients, physicians, hospitals, and other health care providers.

While initial savings may be generated by competitive bidding, the savings may be counterbalanced by a loss in the quality of health care services and diminished access to care where the "winning" bidder is remote from the patient, or where "non-winners" cut back on their provision of the particular service. Such savings are short-sighted and carry the high potential for a negative health care outcome.

We continue to maintain that the competitive bidding mechanism for selecting a provider of such distinct and individual care services is just not appropriate. Serious questions that ultimately revolve around the quality of care provided readily arise:

- How would quality of the provider bidding on the services be determined?
- Would providers be allowed to bid on services that are outside of their current area of service provision?
- Would turn-around time be affected by the bid price?
- Will patients be inconvenienced or costs increased if physicians are unable to provide or attain special services through their offices or other settings?
- Would the competitive bid process force losing competitors out of business, thereby limiting access to care?
- How is the bid area to be defined? What would be the impact of a national or regional provider of services on the bid? How would such a provider participate in the bid process?

In addition to the specific questions raised here, serious consideration must be given to the future of the health care industry in an area where a competitive bid demonstration is allowed. Under the current system, a large number of entities may deliver services, price information should be readily available, and physicians and their patients are free to elect to have services provided by one provider as opposed to another. Where there is dissatisfaction with the provider services, physicians and their patients should have the option of voting with their feet and going to a new provider. Under a competitive bid system, this ability will be either eliminated or greatly diminished. There has been some experience in this area with the competitive bidding of pap smears by some states. Unfortunately, the results were often poor quality. As a result, those contracts have been terminated.

Under a competitive bid program, dissatisfied beneficiaries are unable to exercise true freedom of choice. Eliminating freedom of choice eliminates a major quality check that oftentimes is a patient's or referring physician's only significant option in directing care: the ability to seek care from the complete range of physicians and other health care providers.

We urge rejection of competitive bidding as a means to purchase unique health and medical care services. Being a low bidder carries no guarantee of quality. In a truly competitive market, purchasers are free to elect to receive services from the provider of their choice. This would not be the case in a competitive bid environment and the end result is one where it is the potential recipient of the services who may suffer. Our patients stand to be the ultimate losers from such a direction that clearly is contrary to the important goal of free choice.

CENTERS OF EXCELLENCE

President Clinton's proposed "Health Security Act" would provide the Secretary with broad authority to enter into contracts, using a competitive process, with "centers of excellence." This would be done for cataract surgery and for other services deemed appropriate by the Secretary. All payments made to such centers, including payment for physicians' and other professional services would be made directly to the center. The proposal is silent as to criteria for or the definition of "centers of excellence."

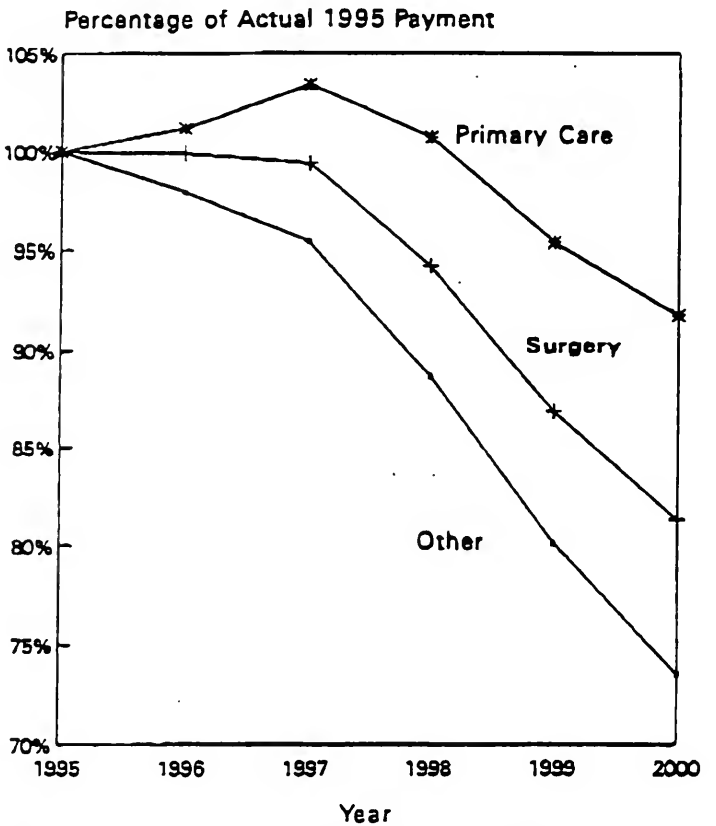
The AMA questions the feasibility of establishing "centers of excellence" using a competitive process as a way to either contain Medicare costs or improve quality. Several questions arise in considering the "centers of excellence" proposal:

- How many of these "Centers" will be established in a given geographical area?
- How far will Medicare beneficiaries be required to travel to receive health care services at these centers, and how will follow-up care be provided?
- If key individuals on the medical staff in one of these centers leave, does the center lose it "excellence" rating?
- If a Medicare beneficiary is unable or unwilling to receive care through a convenient "center of excellence" for a particular service, will reimbursement be denied?

- What happens if the best health care facility providing a specific health care service refuses to bid on being designated a "center of excellence"? Will Medicare beneficiaries be denied the services of this facility?

Furthermore, physicians who are not providing services through one of these "centers of excellence" and other non-designated facilities could be perceived by the public as providing poor quality services. This would be a serious misperception and an unfortunate result of establishing these "centers of excellence." The AMA believes that too many problems arise to justify establishing "centers of excellence" as a formal part of the Medicare program.

Medicare MVPS and Conversion Factor Cuts
Health Security Act, S. 1757



American Medical Association, April 1994-Data from Physician Payment Review Commission, April 1994
Change in conversion factor only. Assumes past volume trends and S. 1757 MVPS/conversion factors

PREPARED STATEMENT OF GEORGE HALVORSON

Good morning. I am George Halvorson, CEO of HealthPartners HMO in Minneapolis, and chairman-elect of the Group Health Association of America (GHAA).

HealthPartners is a 600,000-member, consumer-governed, nonprofit HMO that includes Group Health, Inc., a staff-model HMO, and MedCenters Health Plan, a group-model HMO. HealthPartners currently has over I 6,000 Medicare beneficiaries enrolled in our Medicare risk contract, and almost 6,000 Medicare beneficiaries enrolled in our Social HMO.

I am here today testifying on behalf of GHAA, which represents 350 health maintenance organizations (HMOs) with 33 million members who account for about 75 percent of total HMO enrollment nationwide. Almost 90 GHAA member plans have risk contracts with the Medicare program. This represents 77% of plans that participate in the program and 92% of the enrollment in the program. Our members also participate in the program under cost-based contracts.

HMOS, MEDICARE, AND HEALTH CARE REFORM

I am pleased to be here to talk about the role of HMOs in the Medicare program both today and in the future as health care reform takes place. In the course of my testimony, I will address the five following major areas:

- the advantages of HMO membership for Medicare beneficiaries;
- policies needed to retain and expand HMO membership as an option for Medicare beneficiaries in the future;
- problems with the current Medicare risk reimbursement system;
- S. 1996, Senator Durenberger's bill to improve the Medicare risk contracting program; and
- provisions of the Administration's health care reform proposal that would impact HMO Medicare contracting.

BACKGROUND

HMOs are care systems that deliver that care through teams of health care professionals. Their primary goals are keeping their members well and providing high-quality, coordinated health care. Consumers consistently give HMOs positive reviews, which are reflected in high enrollment renewal rates. In fact, HMO enrollment has quadrupled during the past decade alone based almost entirely on consumer choice. Today, about 45 million people—*roughly one out of every five Americans who have health insurance—are enrolled in HMOs,* and GHAA estimates that HMO enrollment will exceed 50 million by the end of 1994. The vast majority of these HMO members selected their plans in an environment of choice—they chose to be our members.

What is it about HMOs that makes them attractive? HMOs organize the delivery of comprehensive health care services in a way that makes a great deal of sense to many Americans. The benefit packages we offer tend to be significantly broader and more complete than those offered by indemnity insurers. Out-of-pocket costs are invariably lower. Typically, HMO members benefit from being able to select a personal physician within each health plan who knows their needs and can coordinate any specialty care the members may require. Our members also benefit from predictable, low out-of-pocket costs, and they are not burdened by the need to file claims forms to take advantage of covered benefits. In fact, the administrative systems in many of our plans are much less costly than typical insurance administration in this country—and many plans incur administrative costs that are, in fact, lower than those incurred in single payer systems like Canada.

HMOs promote quality in many ways, including careful selection of providers based on professional qualifications, and interest in working within a coordinated system. Eighty-five percent of HMO physicians nationwide are board-certified, compared to only 60 percent of physicians nationwide. We routinely monitor and analyze ambulatory clinical practices to improve the quality of the delivery system and cost-effectiveness of care in ways that are not available or possible for traditional health care insurance arrangements.

Many policy makers think of HMOs as an urban or suburban phenomenon. In fact, HMOs have a successful track record in rural communities. In 1990, 30 I HMOs served both urban and rural counties, and 15 more served rural counties only. Involvement is growing as doctors, consumers, and administrators find new ways to adapt HMO models to meet the unique needs of rural areas.

Let me speak for a moment about our own health plan. Our plan, for example, has made a commitment to reduce the incidence of heart disease, diabetes, preterm

births, and several other key conditions by 25 percent over the next four years. That type of commitment to real health is only possible in an HMO environment.

CURRENT HMO PARTICIPATION IN THE MEDICARE PROGRAM

Under current law, HMO have three options under which they may contract with the Health Care Financing Administration (HCFA) to provide Medicare covered benefits to Medicare beneficiaries. These options are:

- contracting as health care prepayment plans (HCPPs) on a cost basis to provide some or all of the Part B services;
- contracting as federally qualified HMOs or as competitive medical plans (CMPs) on a cost basis to provide all Part A and Part B services; and
- contracting as federally qualified HMOs or as competitive medical plans (CMPs) on a risk basis to provide all Part A and Part B services. Under this option HMOs are paid based on prospectively determined rates that are intended to reflect 95 percent of the amount HCFA would have paid if the beneficiaries enrolled in the HMO had remained in the fee-for-service Medicare program (95 percent of the adjusted average per capita cost [AAPCC] of providing the covered benefits).

As of March 1, 1994, approximately 600,000 Medicare beneficiaries were enrolled in HMOs with HCPP contracts; 162,000 Medicare beneficiaries were enrolled in HMOs with cost contracts and almost two million Medicare beneficiaries were enrolled in HMOs with risk contracts.

- Advantages of HMO Membership for Medicare Beneficiaries

Medicare beneficiaries are already realizing some of the central goals of health care reform. They have access to affordable, high quality, comprehensive benefits in exchange for a fixed monthly premium. Medicare HMO members receive all Medicare covered benefits but in addition, they also have access to comprehensive coverage at affordable and totally predictable cost.

This is possible because under the risk contracting program, HMOs return to the beneficiaries in the form of added benefits any difference between 95 percent of the AAPCC (intended to represent the fee-for-service cost of providing the Medicare benefits) and the premium the HMO would need to provide Medicare covered services. Beyond the benefits HMOs can provide with the "savings" generated by cost-effective care, most HMO Medicare risk contractors also add benefits that make Medicare beneficiaries' coverage closer to the comprehensive benefits offered to other HMO members.

Over 42 percent of Medicare beneficiaries are charged premiums for their HMO coverage of less than $20 per month. Almost half of premiums for these coverages cost less than $50 per month. The HMO premium includes the Medicare enrollee's Medicare deductibles and coinsurance. This means that these Medicare out-of-pocket costs are translated into a predictable amount per month, rather than being imposed at the time of service.

Indicative of the importance of preventive services to HMOs is the fact that over 97 percent of plans cover routine physicals; almost 90 percent cover immunizations; over 80 percent cover eye exams; and 65 percent cover ear exams, which are not otherwise covered by Medicare. Other services included by HMOs include health education, outpatient drugs, foot care, and dental services. Over one-third of HMOs with Medicare risk contracts include an outpatient prescription drug benefit, a benefit that is highly valued by seniors.

The positive impact of HMO enrollment on the health care of Medicare beneficiaries was documented in a study published by Mathematical Policy Research, Inc., last December. The study demonstrated the benefits of Medicare beneficiaries' receiving coverage through HMOs. These benefits included increased access to care; quality of care that is at least the same, and in many cases superior to fee-for-service care—while using fewer resources; an increased range of choices for beneficiaries; more coverage at lower costs; high member satisfaction; and a potential to generate Medicare program savings.

The study found that about 90 percent of HMO members rated their HMO care as good or excellent. Members were particularly satisfied with the plans' affordability. Fourteen of fifteen HMO members would recommend their HMO to a friend or family member. This is a key indicator of satisfaction with health care. Many other studies also illustrate HMOs' record of quality.

- A study published in *Medical Care,* for example, showed that "For five of six (cancer) screening tests examined . . . members of HMOs are significantly more likely to have received the test within the last three-year period." (*Medical Care,* 1991)

- Another study comparing treatment decisions among 140,000 Californians with clogged coronary arteries found that HMOs offer the best way to avoid unnecessary medical treatment without sacrificing needed care. *(New England Journal of Medicine,* December 9, 1993)

In addition, Medicare risk contracting HMOs serve a disproportionate number of low-income beneficiaries. HMOs reduce financial barriers to care—*annual out-of-pocket costs for the average HMO member are $600 less than in Medicare fee-for-service—including the HMO premium.* HMOs therefore protect beneficiaries from catastrophic financial costs. HMOs do not impose lifetime maximums or spell of illness limitations on benefits. Medicare risk contracting HMOs provide an affordable choice for comprehensive coverage to low-income elderly—those unable to afford insurance industry Medigap premiums and significant, unpredictable, out-of-pocket costs.

FOUNDATION FOR EXPANDING HMO PARTICIPATION IN THE MEDICARE PROGRAM

As the health care reform debate moves forward, decisions will be made about the impact of reform on the Medicare program and whether to include the program in any restructuring of the nation's health benefits marketplace. We believe Medicare beneficiaries should have a chance to choose among delivery systems. Expansion of the availability of HMO membership will be an important aspect of this right to choose.

GHAA believes that existing Medicare contracting opportunities for HMOs—although they can and should be improved—have created a solid foundation for the future. From this experience several elements can be identified that will be important to fostering future HMO participation in the Medicare program, regardless of its treatment in the context of health care reform.

These elements include the following:

- Maintain the opportunity for HMOs to receive capitation, so that care will not be compromised and constrained by the inherent limitations of the traditional Medicare fee-for-service payment approach.
- Permit HMOs to offer a broader benefit package than Medicare covered benefits. HMOs emphasize preventive. care, early intervention, and coordination of care in order to provide high-quality, cost-effective services. If they were required to offer benefits limited to the Medicare benefit package, they would lose the capability to cover services that are essential to meeting these goals. (We, for example, have cut the readmission rate for seniors with congestive heart failure in half with a special program that involves putting special scales in their homes and having nurses call each patient daily to check on their weight and health status. That program has significantly improved the health status of the seniors involved, and it reduces costs—because it reduces hospitalizations. That program, and others like it, would not qualify for reimbursement under traditional Medicare fee-for-service payment. Medicare only pays for sick people, not for keeping people well.)
- Retain HMOs' ability to enroll Medicare beneficiaries outside the risk contracting program. It is difficult for HMOs with small numbers of members to absorb the random cost of illness for Medicare beneficiaries. For some HMOs, current cost-based reimbursement mechanisms provide an opportunity to gain experience in meeting the special needs of Medicare beneficiaries without incurring the significant financial risk that can accompany risk-based reimbursement.
- Improve the highly flawed and inconsistent reimbursement mechanism in the current Medicare risk contracting program, which is currently based upon the adjusted average per capita cost (AAPCC) calculation.
- Assure Medicare beneficiaries a choice among health care delivery systems, including both HMO or other managed care offerings and fee-for-service coverage.

IMPROVEMENTS IN THE MEDICARE RISK CONTRACTING PROGRAM

Despite the overall growth in the number of people in the U.S. who are receiving their health care through HMOs, there has not been parallel growth in the number of Medicare beneficiaries enrolled in HMOs. This has been primarily due to a relatively low level of HMO participation in Medicare—and not due to consumer reluctance to join HMOs. Consumers join HMOs where they are offered. Only one-fifth of plans are currently participating in the program. They serve around four percent of Medicare beneficiaries nationally.

Inadequate capitation rates are the major reason for the relatively low participation of HMOs in risk contracts, and thus the low rate of growth in program enrollment. Such inadequate rates are a particularly serious barrier to participation in rural areas. Key problems are:

- The rates are unstable from year to year, which makes planning difficult, if not nearly impossible, for HMOs.
- The rates are not sufficiently risk adjusted to reflect the risk mix across different contractors.
- The geographic area on which the rates are based is the county in which the beneficiary resides. Counties do not adequately reflect patterns of health care services or health plan market areas. Rates in adjacent counties vary significantly and haphazardly. The only consistency seems to be an inadvertent discrimination against rural counties and areas where the health care providers are cost efficient.
- The rates are tied to the traditional fee-for-service costs in a given area, and not to HMOs' costs of providing health care. One very interesting fact that you should consider carefully is that the AAPCC tends to be significantly lower in areas that have high HMO enrollment because of the "spillover effect." This makes perfect sense. Physicians who have adopted a more efficient practice style, because of participating in HMOs are likely to practice the same style of care with their fee-for-service patients. That change in behavior reduces fee-for-service costs and, because of the AAPCC formula's link to fee-for-service that efficiency reduces AAPCC rates as well. In other words, the payment approach creates a penalty for efficiency. It is hard to argue that that's good policy.

GHAA has developed a list of general principles that should be used to evaluate proposals for new or revised Medicare risk payment methodology. The method should:

- be perceived as being objective and fair, and support efficiently operating delivery systems, even when the systems enroll populations that consume substantial health care resources;
- result in relatively stable and predictable payments, with appropriate recognition of valid year-to-year changes in input costs;
- reward improvements in the efficiency of the market;
- adequately adjust for differences in the illness burden of beneficiaries;
- recognize appropriate variations in local utilization patterns and practice style as they influence HMO, health care practice;
- recognize appropriate and legitimate local variations in local input costs; and
- be relatively easy for the government to administer.

COMMENTS ON PROPOSED CHANGES TO THE, PAYMENT METHODOLOGY FOR RISK CONTRACTS

Several bills have been introduced that would change the current risk contracting payment methodology. Our comments today are focussed on Senator Durenberger's Medicare Choice Act of 1994, and the Administration's Health Security Act.

S. 1996, MEDICARE CHOICE ACT OF 1994

We are pleased that Senator Durenberger has given improvement of the Medicare risk contracting program a high priority, and that he has introduced the Medicare Choice Act of 1994. The bill incorporates important principles of consumer choice among delivery systems for beneficiaries. It also calls attention to the need for comparative information on health plan offerings that will permit Medicare beneficiaries to make truly informed choices. In addition, it acknowledges that the reimbursement mechanism must be improved in order for HMO options for Medicare beneficiaries to expand significantly in the future.

Important issues addressed by the bill include:

- consideration of a newly defined geographic areas for rate setting purposes. The current county basis on which the AAPCC rates are calculated is clearly unsatisfactory to all parties—the seniors, the government, and the health plans—and the Medicare market areas proposed in S. 1996 deserve further examination.
- introduction of a bid process into the rate-setting mechanism also has been considered by a GHAA Technical Panel, primarily composed of actuaries. The Panel found that a bid process holds promise for improving the reimbursement mechanism. However, using only the lowest bid in the establishment of Medicare payment levels could also create year to year instability in the rates. Averaging low bids or using an alternative method that would limit significant unpredictable fluctuations in payment should be included.

The bill also proposes that health plans must offer either the Medicare benefit package, including the Medicare cost-sharing levels, or "actuarially equivalent Medicare benefits," which would include all Medicare covered benefits with cost-sharing actuarially equivalent to the Medicare coinsurance and deductibles. GHAA urges reconsideration of this requirement, since it would be extremely difficult to calculate

and would also have the effect of requiring HMOs to offer benefits less comprehensive than those necessary for the efficient delivery of high-quality care. Coverage of preventive services and a coordinated approach to care management that uses different settings of care, when appropriate, are critical to HMOs' basic benefit offerings.

GHAA also is concerned about the coordinated open enrollment requirement. Medicare beneficiaries must be individually contacted and given a full explanation of the way in which HMO services are delivered by providers to ensure that beneficiaries are making an informed choice about HMO membership. Although comparative information about health plans is important, it is unlikely to be enough by itself to communicate the information needed by beneficiaries to make the right personal choice about joining an HMO.

Currently, many HMOs enroll Medicare beneficiaries on a year-round basis in order to permit adequate time for the contact necessary to fully inform prospective members and to accommodate the needs of employers for coverage of retirees. Additionally, enrollment of large numbers of Medicare beneficiaries at a single time of year could stress both administrative and delivery systems of HMOs. A more flexible approach to enrollment would be beneficial to both health plans and Medicare beneficiaries.

ADMINISTRATION'S HEALTH CARE REFORM PROPOSAL

While we find significant areas to support in the Administration's bill, such as comprehensive benefits and universal coverage, GHAA opposes the provisions that would add an arbitrary ceiling and floor to the AAPCC payment methodology, and it would drive HMOs away from Medicare rather than attracting us to it. There is wide recognition that the AAPCC payment mechanism is flawed, and any efforts to alter HMO risk-based Medicare reimbursement should address the underlying problems with the calculation rather than ignoring them.

The reduction that will result from application of the ceiling particularly inequitable since it is proposed in combination with a compounding reduction in the fee-for-service Medicare payments that create the AAPCC. In other words, this reduction would unfairly penalize risk contracting HMOs since they will already be impacted by Medicare cuts on the fee-for-service side. HMOs participating in Medicare risk contracts would thus be affected by fee-for-service reductions in several ways.

GHAA also opposes the proposal in the Administration's bill that would establish an outlier pool for high-cost cases, which would be funded by reducing the AAPCC. This is an expensive and unnecessary bureaucratic involvement in the risk process—and it will also discourage HMO involvement in Medicare because it will be seen as a mechanism to cut Medicare costs. If the pool is not drawn upon by risk contractors with high-cost cases, then it will simply be an unfair way of reducing HMO payments.

The fact is that the outlier pool is not necessary—commercial reinsurance is already available to HMOs who need it, and HMOs with sufficiently large enrollment self insure. It would be burdensome for HMOs to justify that they have high cost cases that qualify for the outliers, since HMOs that capitate providers may not have data readily available on costs for providing care to individual beneficiaries. It also would be burdensome for HCFA to audit the documentation produced by the risk contractors. The primary impact of the provision would be to increase administrative costs for the government and the HMOs, and to discourage HMOs from working with Medicare.

Conclusion: HMOs and Medicare Under Health Care Reform

Under health care reform, regardless of how the Medicare program is treated, there should be a strong commitment to offering Medicare beneficiaries a choice of delivery systems. HMO Medicare beneficiaries should continue to enjoy the same advantages of HMO membership as other HMO members—high quality, affordable, comprehensive health care services.

GHAA and I look forward to working with the Committee. We are pleased that Senator Durenberger has focussed attention on the Medicare risk contracting program. We hope to be able to add our expertise to further refinements of the proposal.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

Mr. Chairman and members of the Committee:

My name is Allan Jensen. I am an ophthalmologist in private practice in Baltimore and Secretary for Federal Affairs for the American Academy of Ophthalmology.

On behalf of the Academy's 20,000 ophthalmologists—physicians who provide primary and comprehensive medical and surgical eye care—I am pleased to have this opportunity to present this statement.

The American Academy of Ophthalmology strongly believes that all Americans should have access to quality health care including appropriate and affordable eye care. We believe that an appropriate level of eye care is necessary in order to promote general well-being, independent daily functioning, enhanced quality of life and increased economic productivity.

The Academy commends the Finance Committee for its attention to Medicare issues associated with health system reform. As the Committee moves forward with its consideration of Medicare, we wanted to bring your attention to a specific issue of great importance to ophthalmology and our patients—"centers of excellence."

Section 4135 of the Health Security Act mandates the establishment of centralized government-endorsed surgical centers or so-called "centers of excellence" in urban areas throughout the country. Services provided at these centers would include coronary artery bypass surgery (CABG), cataract surgery and other surgical procedures determined by the Secretary of Health and Human Services. A rebate payment would be provided directly to those patients who received services at the centers.

The basis of the "centers of excellence" concept, as it relates to cataract surgery, is the Medicare Cataract PPO Demonstration project. This project, initiated by the Health Care Financing Administration (HCFA) in 1993, was developed as a means of testing "the feasibility of an alternative pricing arrangement for episodes of cataract surgery."

Project demonstration sites currently include Cleveland, Ohio; Dallas/Ft. Worth, Texas; and Phoenix, Arizona. Providers at these sites are paid on a negotiated discounted global fee basis by Medicare. This fee includes the costs of the physician and facility, intraocular lens, and selected preoperative and postoperative tests and visits.

The Academy strongly opposes the expansion of the Medicare Cataract PPO Demonstration project in the form of "centers of excellence" for the following reasons:

QUALITY OF CARE PROBLEMS

The Academy strongly believes that cataract surgery is not appropriate for "centers of excellence." The centralization inherent to the "centers" concept may be appropriate for procedures such as transplants and coronary artery bypass (CABG) but not necessarily for cataract surgery.

For complex inpatient procedures such as CABG, outcomes commonly vary significantly among providers. Centralizing procedures with providers of known superiority or "excellence" could result in improvements in quality.

Cataract surgery patients, by contrast, would not benefit from this centralization of providers. Cataract surgery is a widely accessible outpatient procedure performed by most community ophthalmologists. "Excellence" is already widespread as the Department of Health and Human Services' Agency for Health Care Policy and Research (AHCPR) has determined that the success rate for the procedure is 95-percent. It is highly unlikely that centralized cataract surgery centers could improve on this success.

Today's community-based ophthalmologists follow their patients over the patient's lifetime. The ophthalmologists are aware of the patient's medical history and are aware of conditions such as diabetes and other systemic problems. This knowledge allows the physician to make appropriate clinical decisions that ensure quality patient care.

The cataract "centers" performing a single procedure will unnecessarily splinter this long-term physician-patient relationship. As a result of the rebate payment offered by the "centers," patients will be drawn out of the relationship at a time when appropriate clinical decisionmaking is most critical—when surgery is necessary. The quality of care will suffer needlessly as a result of this disruption.

NECESSITY OF CARE PROBLEMS

The Academy also is concerned that the cataract "centers of excellence" could result in significant necessity of care problems. The community-based ophthalmologist, providing comprehensive eye care over the long-term, has assessed the patient's visual functions and understands the patient's visual needs, i.e., the patient may read extensively or drive a truck for a living. With this knowledge, the physician can work with the patient to decide if surgery is necessary. Surgery is offered as an alternative only when it is in the patient's best interest. There is little incentive to perform a procedure prematurely.

By contrast, the providers at the "centers of excellence" have no long-term relationship with the patient. The "centers" can succeed only if their negotiated discounted bundled fee is offset by increased volume in surgical procedures performed. In effect, this requirement for volume creates a government-endorsed incentive to perform surgery. Unethical and unnecessary care could result.

This threat of inappropriate care is further exacerbated by the rebate payment provided to patients who undergo surgery in the "centers." The Academy questions whether the Federal government should be paying individuals to receive surgical care.

ACCESS PROBLEMS

The Academy also believes that, by centralizing surgery in urban areas, the "centers of excellence" proposal creates an additional access problem for the rural elderly. These elderly would be encouraged to travel potentially longer distances for outpatient surgery and follow-up care. Centralization would only add to the predicament of rural providers struggling to maintain their patient base and practice.

CONCLUSION

In conclusion, the Academy believes that cataract patients, who are most often elderly, receive the highest quality, most cost efficient care from community-based ophthalmologists who work hand-in-hand with their patient's general practitioner or family doctor. Encouraging these older Americans—among the nation most vulnerable—to leave their community-based provider could result in unnecessary care and diminished quality outcomes. For this reason, the Academy urges the removal of cataract surgery from the "centers of excellence" provisions.

The Administration estimates approximately $110 million in savings per year from the "centers of excellence" provisions. The Academy estimates that removing cataract surgery from this section will reduce total savings by approximately one-third. The majority of savings from the "centers" provisions come from CABG whose total Medicare costs (including facility costs), are nearly twice that of cataract surgery.

We thank the members of the Committee for their attention to this important issue and we appreciate the opportunity to present this statement to you.

STATEMENT OF AMERICAN HEALTH CARE ASSOCIATION

Chairman Moynihan, Senator Packwood and members of the Senate Finance Committee, the American Health Care Association (AHCA) appreciates the opportunity to provide you with our Association's position on the Medicare changes proposed in the President's Health Care Reform proposal. AHCA is a federation of 51 affiliated associations representing 11,000 non-profit and for-profit nursing facilities, residential care, and subacute providers nationally.

AHCA is strongly opposed to the reduction in Medicare's routine cost limits for skilled nursing facilities (SNFs) and supports the establishment of a prospective payment system for Medicare reimbursement to those facilities.

REDUCTION IN ROUTINE COST LIMITS FOR SKILLED NURSING FACILITIES

AHCA strongly opposes Section 4106 of the President's Health Care Reform Plan. Section 4106 dramatically reduces the ceiling on routine costs for services provided by SNFs. This provision will devastate SNFs' ability to provide quality care for current and future residents. Further, it is contrary to the Congressional intent to establish a prospective payment system for SNFs.

Section 4106 would reduce the maximum amount reimbursable for routine skilled nursing services from 112% of the mean to 100% of the mean (or less if determined by the Secretary of Health and Human Services) to preserve the effects of the existing freeze in 1995. The Administration projects reimbursement to be reduced by $830 million in fiscal years 1996–2000. AHCA strongly opposes the reduction in routine cost limits for SNFs for three reasons:

- This reduction will have a dramatically negative impact on the quality of resident care. Our data indicate it will reduce reimbursement to each SNFs by an average of $65,000 in 1998 alone.
- This proposal is contrary to Congress' expressed intent to have a prospective payment system for SNFs in place by October 1, 1995; and
- This reduction will significantly reduce the effectiveness of Sec. 1119, the extended care or subacute benefit which facilitates the movement of patients in need of inpatient services into facilities that are an alternative to costly hospital care. Such a drastic reduction in routine cost limits will make it extremely difficult for SNFs to provide care to subacute patients eligible for this benefit.

AHCA estimates, based on HCFA data, demonstrate the impact the reduction will have on providers. We estimate that:

- By 1998, with a freeze in routine cost limits, at least 60% of nursing facilities will not get reimbursed for the full costs of their Medicare residents. Should acuity or utilization increase in response to the demand for cost effective subacute care, the percent will be much higher. Currently, 26% of facilities' costs exceed their reimbursement.
- Total cumulative unreimbursed costs between 1994 and 1998 will be nearly $2 billion. In 1998, unreimbursed costs will be $675 million, equalling 12% of total costs. This means an average unreimbursed cost of *$65,000* per nursing facility in that year alone. This equals the salaries of five nursing assistants.
- To preserve the effect of the freeze, the routine cost limit will have to drop from the current 112% of average facility costs to at least 100% in 1995 and then down to 90% in 1998.

This will occur as the nursing industry is reeling from $1.1 billion in Medicare cuts from the Deficit Reduction Act of 1993. The attached charts demonstrate the effect of that reduction by state. In that bill our ability to raise capital was curtailed with the repeal of Return on Equity. The proposed cut will force facilities to reduce staff. These actions which curtail capital and staff make it extremely difficult to care for residents including the subacute patients.

Section 4106 maintains the current inefficient retrospective reimbursement system. Instead of exacerbating the problems of the current system with deep and arbitrary cuts, a new Section 4106 should be adopted that establishes a prospective payment system that reimburses all SNFs based on resident acuity, efficiency incentives, and fair-value rental for property administrative costs.

MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES

Congress have expressed an increasing interest in establishing a prospective payment system for SNFs. In the mid-1980s, Congress created a prospective payment option for low-volume Medicare SNFs. Then, with the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress asked the Health Care Financing Administration (HCFA) and the Prospective Payment Commission (ProPAC) to analyze a prospective payment option and report their findings to Congress. Finally, the OBRA '93 report language directed HCFA to design and install a prospective payment system for SNFs by October 1, 1995.

At the same time that Congress has been examining a prospective payment for Medicare, the states have been rapidly introducing prospective payment systems for Medicaid. Nearly every state Medicaid payment system is prospective in nature, of those almost half include some form of case-mix payment, about one-third utilize some form of fair-value rental payment for property costs, and most use explicit payments as efficiency or quality incentives. Properly funded, many of these systems provide the proper balance among the competing demands of efficiency, quality, and cost savings.

It is certainly legitimate to ask why Congress' interest is so keen on prospective payment for Medicare, while states have been similarly focused on prospective pay-

ment for Medicaid. The reason is that the retrospective, cost pass-through payment system that Medicare currently employs (and that most Medicaid programs started with) offers providers no reward for balancing efficiency and cost-saving efforts, with acceptable levels of patient care and access.

AHCA has developed a prospective payment system design using the collective experience of the states. The AHCA design is an opportunity to achieve goals beyond the current Medicare payment system. Specifically, it can achieve: equal access for heavy-care patients (including subacute care); quality care for all Medicare patients; efficiency incentives for providers; and cost savings for the Medicare program.

The prospective payment system design achieves multiple goals by identifying five separate cost centers and establishing targeted goals for each. The cost centers, their goals, and the mechanisms used to achieve those goals are briefly described below:

Nursing service costs will be paid using a facility specific, prospective rate that is determined each year from each facility's nursing service costs and its patient case mix relative to the industry as a whole. The case-mix score of each facility will be measured annually using patient data from the MDS or MDS+ applied to a RUG III patient classification system. Payment rates for heavy-care patients will be enhanced with a small, but effective access incentive. This attention to nursing service costs and the use of payments that vary by patient acuity will enhance quality care and ensure equal access to care for patients of all acuity levels.

Administrative and general costs will be paid at facility specific, prospective rates determined annually from the relationship of each facility's administrative and general costs to a fixed industry standard. The more efficient the facility, the more economically healthy it is and the greater the prospects for cost savings to the Medicare program since the gains from efficiency are shared between the provider and the Medicare program. The single focus for this cost center is cost containment achieved through facilities lowering costs in the pursuit of efficiency incentives.

Therapies are to be paid on a fee-for-service basis with the fees established through data on therapy costs submitted annually by each facility. Payments then are made as units of therapy services are provided to Medicare patients in the facility. Clearly, the goal is to provide quality care by ensuring that patients with rehabilitative potential receive adequate therapy services.

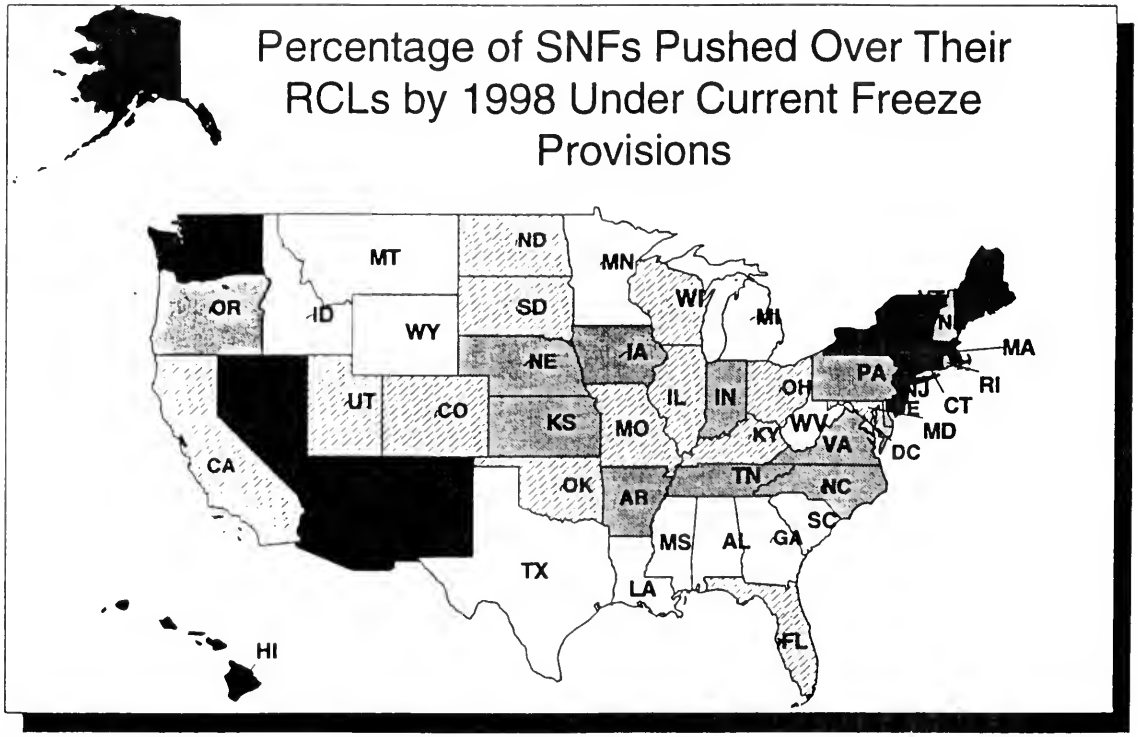
Property costs are to be paid through a fair-value rental system that focuses on the economic use value, rather than the accounting costs, of the land and physical plant. This involves establishing each year the current value of the land and physical plant of each provider and paying a rental based on the yield of long-term treasury bonds in the recent past. The focus here is quality care and a fair return on the capital investment of the provider.

The last cost center includes minor ancillaries that cannot be paid on a prospective per diem because of their high interfacility variation, raw food that needs to be protected in the interests of quality care, and property taxes and property insurance costs that are highly variable from jurisdiction to jurisdiction and over which facilities exercise little control.

The proposed system is based on the collective experience of state payment systems and draws in particular from the Mississippi system which has proven to work quite well. This system addresses the deficiencies in the current Medicare system while ensuring access to quality care for its beneficiaries.

CONCLUSION

AHCA strongly requests that the Senate Finance Committee substitute the current Section 4106 in the President's health care reform proposal with a new provision establishing a prospective payment system for Medicare reimbursement to SNFs. We are willing to work with the Committee on this important issue.

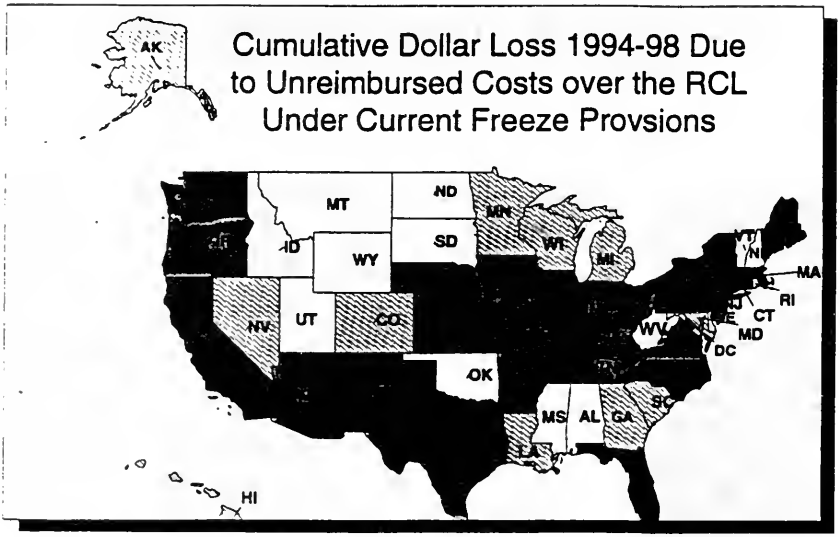

Percentage of SNFs Pushed Over Their RCLs by 1998 Under Current Freeze Provisions
ND
MN
MT
OR
ID
WY
SD
WI
MI
NE
IA
PA
NJ
RI
CT
MD
DC
UT
CO
KS
MO
IL
IN
OH
KY
WV
VA
CA
OK
AR
TN
NC
SC
MS
AL
GA
TX
LA
FL
HI
Percent of SNFs Over RCLs
0.814286 to 1 (13)
0.628889 to 0.814286 (13)
0.505181 to 0.628889 (13)
0.166667 to 0.505181 (12)

Four Year Impact of Current Medicare Freeze Provisions on Skilled Nursing Facilities

Table 1: Percent Over Their RCLs

	Number of SNFs	1994	1995	1996	1997	1998
National	10370	36.5%	42.5%	49.0%	55.2%	61.1%
Alabama	201	10.3%	12.8%	17.1%	21.4%	28.2%
Alaska	6	100.0%	100.0%	100.0%	100.0%	100.0%
Arizona	113	51.4%	64.3%	68.6%	72.9%	81.4%
Arkansas	75	66.7%	66.7%	66.7%	66.7%	66.7%
California	1084	32.4%	38.1%	43.9%	49.1%	52.4%
Colorado	143	30.4%	32.1%	37.5%	44.6%	53.6%
Connecticut	224	57.8%	68.4%	72.7%	79.7%	87.5%
Delaware	31	40.0%	46.7%	53.3%	80.0%	80.0%
District of Columbia	13	100.0%	100.0%	100.0%	100.0%	100.0%
Florida	524	27.0%	31.8%	38.4%	45.6%	55.0%
Georgia	229	23.1%	29.2%	30.8%	35.4%	40.0%
Hawaii	28	66.7%	80.0%	86.7%	86.7%	86.7%
Idaho	72	11.3%	18.9%	22.6%	32.1%	37.7%
Illinois	383	36.2%	42.7%	47.4%	53.0%	57.8%
Indiana	345	37.4%	43.6%	54.0%	62.0%	73.6%
Iowa	75	78.1%	81.3%	81.3%	81.3%	81.3%
Kansas	104	51.2%	53.7%	53.7%	56.1%	63.4%
Kentucky	259	35.1%	40.3%	46.8%	54.5%	59.7%
Louisiana	36	38.9%	44.4%	44.4%	44.4%	44.4%
Maine	99	80.0%	80.0%	86.7%	93.3%	93.3%
Maryland	168	24.5%	34.9%	38.7%	47.2%	56.6%
Massachusetts	383	82.7%	85.5%	90.0%	94.5%	96.4%
Michigan	338	15.4%	20.0%	25.0%	29.6%	32.7%
Minnesota	429	10.9%	15.2%	20.7%	30.1%	41.3%
Mississippi	65	0.0%	0.0%	0.0%	16.7%	16.7%
Missouri	305	32.0%	41.0%	50.8%	55.7%	57.4%
Montana	95	16.4%	21.3%	24.6%	31.1%	47.5%
Nebraska	71	65.2%	65.2%	69.6%	78.3%	78.3%
Nevada	35	72.7%	77.3%	86.4%	86.4%	95.5%
New Hampshire	19	55.6%	55.6%	66.7%	66.7%	77.8%
New Jersey	222	51.1%	61.5%	71.9%	77.8%	83.7%
New Mexico	54	53.3%	66.7%	73.3%	86.7%	86.7%
New York	626	75.7%	82.0%	89.1%	92.5%	95.3%
North Carolina	350	49.1%	53.5%	59.6%	69.3%	78.1%
North Dakota	84	22.2%	33.3%	50.0%	61.1%	61.1%
Ohio	569	25.9%	30.6%	36.0%	42.2%	50.5%
Oklahoma	33	28.6%	57.1%	57.1%	57.1%	57.1%
Oregon	113	47.2%	48.6%	63.9%	70.8%	79.2%
Pennsylvania	581	34.2%	42.0%	50.2%	57.8%	62.9%
Rhode Island	99	34.0%	43.4%	56.6%	62.3%	79.2%
South Carolina	143	27.3%	30.3%	40.9%	45.5%	50.0%
South Dakota	43	28.6%	28.6%	28.6%	57.1%	57.1%
Tennessee	173	38.3%	49.4%	58.0%	65.4%	71.6%
Texas	472	18.0%	20.5%	25.0%	29.5%	33.0%
Utah	61	32.4%	35.1%	40.5%	45.9%	54.1%
Vermont	27	46.7%	73.3%	86.7%	86.7%	93.3%
Virginia	174	47.1%	52.9%	61.4%	71.4%	74.3%
Washington	265	56.5%	66.7%	72.2%	79.6%	85.2%
West Virginia	64	21.4%	35.7%	39.3%	42.9%	42.9%
Wisconsin	239	23.9%	31.0%	40.8%	49.3%	57.0%
Wyoming	28	33.3%	33.3%	50.0%	50.0%	50.0%

American Health Care Association 02/01/94 S:\ANALYSIS\REIMB\MEDICARE\CYCLE11\PAULFZ.WB1


Cumulative Dollar Loss 1994-98 Due to Unreimbursed Costs over the RCL Under Current Freeze Provsions
AK
HI
MT
ND
MN
ID
WY
SD
WI
MI
NV
UT
CO
OK
MS
AL
GA
SC
LA
WV
VT
NH
MA
RI
CT
MD
DC
Dollar Loss: 1994-1998
-601122852.2 to -53244929.45 (12)
-53244929.45 to -19133204.85 (13)
-19133204.85 to -8107530.14 (13)
-8107530.14 to -60885.14 (13)

Four Year Impact of Current Medicare Freeze Provisions on Skilled Nursing Facilities

Table 2: Unreimbursed Costs over the RCLs

	1994	*1995*	*1996*	*1997*	*1998*	*Cumulative Loss*
National	($194,030,771)	($275,483,134)	($383,792,627)	($518,110,269)	($680,251,694)	($2,051,668,496)
Alabama	($162,076)	($267,207)	($479,014)	($824,195)	($1,476,745)	($3,209,237)
Alaska	($1,309,028)	($1,462,558)	($1,622,229)	($1,788,287)	($1,960,988)	($8,143,090)
Arizona	($4,370,422)	($6,425,755)	($8,049,684)	($9,929,878)	($12,726,185)	($41,501,924)
Arkansas	($4,084,748)	($4,779,309)	($5,501,652)	($6,252,890)	($7,034,176)	($27,652,776)
California	($18,717,658)	($26,755,819)	($37,258,273)	($49,996,796)	($63,346,685)	($196,075,233)
Colorado	($2,220,363)	($2,624,076)	($3,426,061)	($4,582,440)	($6,172,862)	($19,025,803)
Connecticut	($9,685,574)	($13,584,370)	($17,936,186)	($23,430,969)	($30,382,021)	($94,999,120)
Delaware	($333,052)	($477,058)	($685,332)	($1,325,679)	($1,687,063)	($4,508,183)
District of Columbia	($2,171,105)	($2,687,532)	($3,224,615)	($3,763,182)	($4,384,091)	($16,230,525)
Florida	($5,224,484)	($7,618,016)	($11,850,540)	($17,496,539)	($25,962,536)	($68,352,116)
Georgia	($1,733,005)	($2,715,667)	($3,468,426)	($4,768,812)	($6,447,295)	($19,133,205)
Hawaii	($1,677,807)	($2,632,371)	($3,617,751)	($4,439,208)	($5,293,524)	($17,660,661)
Idaho	($78,496)	($163,218)	($239,850)	($418,876)	($598,299)	($1,498,739)
Illinois	($7,596,551)	($10,776,816)	($14,268,390)	($18,840,944)	($24,006,552)	($75,489,253)
Indiana	($4,147,448)	($6,117,882)	($9,493,602)	($13,499,737)	($19,784,997)	($53,043,665)
Iowa	($11,269,162)	($13,309,334)	($14,965,771)	($16,688,465)	($18,480,067)	($74,712,798)
Kansas	($3,468,063)	($4,178,536)	($4,761,328)	($5,612,500)	($7,172,294)	($25,192,722)
Kentucky	($2,649,254)	($3,892,024)	($5,692,585)	($8,302,714)	($11,217,334)	($31,753,911)
Louisiana	($1,663,832)	($2,148,375)	($2,405,128)	($2,672,152)	($2,949,857)	($11,839,343)
Maine	($16,114,059)	($17,912,843)	($21,439,070)	($25,468,019)	($28,048,781)	($109,002,773)
Maryland	($1,368,922)	($2,383,480)	($3,247,773)	($4,837,506)	($7,028,360)	($18,866,041)
Massachusetts	($30,557,785)	($37,234,729)	($45,750,289)	($55,285,234)	($64,303,530)	($233,131,566)
Michigan	($893,378)	($1,583,391)	($2,867,413)	($4,151,254)	($5,645,971)	($15,135,404)
Minnesota	($612,271)	($1,074,149)	($1,857,269)	($3,495,024)	($6,327,799)	($13,366,512)
Mississippi	$0	$0	$0	($17,135)	($43,750)	($60,885)
Missouri	($4,632,185)	($7,140,273)	($10,576,076)	($13,711,748)	($18,411,146)	($52,471,425)
Montana	($90,564)	($162,267)	($244,396)	($389,382)	($786,703)	($1,673,312)
Nebraska	($4,528,928)	($5,437,146)	($6,613,850)	($8,868,668)	($10,129,450)	($35,778,043)
Nevada	($1,406,602)	($1,786,985)	($2,401,662)	($2,824,946)	($3,661,608)	($12,081,793)
New Hampshire	($953,018)	($1,086,682)	($1,480,504)	($1,689,976)	($2,226,802)	($7,436,980)
New Jersey	($6,540,986)	($9,640,376)	($13,763,647)	($17,989,458)	($22,965,101)	($70,899,570)
New Mexico	($2,385,428)	($3,485,131)	($4,485,963)	($6,151,235)	($7,060,203)	($23,567,960)
New York	($71,658,352)	($92,958,700)	[illegible]	[illegible]	($172,142,780)	($601,122,852)
North Carolina	($6,138,066)	($8,212,045)	($11,055,196)	($15,419,617)	($20,917,600)	($61,740,524)
North Dakota	($497,066)	[illegible]	[illegible]	[illegible]	($2,775,852)	($8,107,530)
Ohio	($4,683,100)	($6,697,702)	($9,468,973)	($13,343,969)	($19,051,186)	($53,244,929)
Oklahoma	($556,314)	[illegible]	[illegible]	[illegible]	($2,418,936)	($7,937,807)
Oregon	($2,205,031)	($2,842,284)	($4,618,320)	($6,292,167)	($8,537,336)	($24,495,138)
Pennsylvania	($8,780,291)	[illegible]	[illegible]	[illegible]	($37,947,293)	($109,351,673)
Rhode Island	($738,603)	($1,283,969)	($2,275,024)	($3,349,226)	($5,487,127)	($13,133,948)
South Carolina	($1,061,415)	[illegible]	[illegible]	[illegible]	($4,154,193)	($12,123,272)
South Dakota	($198,887)	($247,669)	($298,402)	($755,632)	($1,003,771)	($2,504,361)
Tennessee	($3,648,587)	[illegible]	[illegible]	[illegible]	($17,881,152)	($60,581,187)
Texas	($1,903,187)	($2,658,572)	($3,955,144)	($5,681,073)	($7,668,392)	($21,864,369)
Utah	($484,552)	[illegible]	($1,030,069)	[illegible]	($2,123,490)	($5,780,480)
Vermont	($147,110)	($367,770)	($660,476)	($902,559)	($1,248,276)	($3,326,192)
Virginia	($4,796,604)	($6,438,032)	($9,863,648)	($12,034,481)	($14,781,357)	($46,984,137)
Washington	($7,773,381)	($11,476,126)	($15,424,025)	($20,623,551)	($26,253,447)	($81,550,531)
West Virginia	($204,179)	($456,123)	($668,532)	($926,996)	($1,157,006)	($3,412,937)
Wisconsin	($909,933)	($1,624,967)	($2,985,527)	($4,948,789)	($7,523,370)	($17,992,566)
Wyoming	($10,681)	($22,806)	($53,491)	($88,155)	($124,205)	($299,337)

STATEMENT OF
ROB SCHWARTZ, PRESIDENT
THE AMERICAN REHABILITATION ASSOCIATION
BEFORE THE SENATE FINANCE COMMITTEE
U.S. SENATE
REGARDING HEALTH CARE REFORM
AND MEDICARE

APRIL 12, 1994

Mr. Chairman:

The American Rehabilitation Association, formerly the National Association of Rehabilitation Facilities ("NARF") appreciates your holding hearings on the subject Medicare and in President Clinton's health care reform plan.

The American Rehabilitation Association (American Rehab.) represents over 900 medical, vocational, and residential community-based rehabilitation facilities. These include the majority of free-standing PPS-exempt rehabilitation hospitals, rehabilitation units, and those PPS-exempt long term hospitals involved in rehabilitation.

American Rehab. has been concerned for a number of years about the current payment methodology for Medicare PPS-exempt rehabilitation hospitals and units and those long term hospitals which serve rehabilitation patients. This methodology, known as TEFRA, for the Tax Equity and Fiscal Responsibility Act of 1992, pays PPS-exempt entities their costs, subject to a limit known as the TEFRA target ceiling limitation. To this end, the Association, at its October 1993 Board of Directors' Meeting, adopted a proposal to put forth to the Congress and the Administration on moving towards a prospective payment system for these PPS-exempt entities, to allow for interim rebasing between the date legislation is enacted and when the PPS would go into effect, and to expand the conditions for exclusion from the PPS.

We recommend that this proposal be considered by the Committee at the time it considers health care reform and as part of any changes it may consider to the Medicare system.

I. Background

For several years, providers of inpatient rehabilitation services have been divided by a fault line created by TEFRA limits on Medicare reimbursement. Hospitals and units that were in existence in the early 1980s generally have low limits, while newer hospitals and units have much higher limits, or none at all. Since Medicare is a major source of revenue for most providers of rehabilitation, representing 60% of inpatient days an average, this is a major issue. The extent of this division can be seen from the data on Attachments 1 and 2, which show the position of hospitals and units relative to TEFRA limits. These data are drawn from cost reports for years ending in 1990 and 1991, the most recent periods available through HCFA.

Some relief was provided for hospitals and units over their limits in OBRA 90, whereby a portion of costs over limits are reimbursed starting with fiscal years beginning on and after October 1, 1991. There is general recognition that the TEFRA system, intended in 1982 to be a temporary measure, is seriously flawed for the following reasons:

1. Medicare pays widely varying amounts for similar services, producing serious inequities among competing institutions.

2. New hospitals and units can establish limits based on contemporary wage levels and otherwise achieve much higher limits than older hospitals.

3. By treating all rehabilitation discharges as having the same economic value, the TEFRA system provides a strong incentive to admit and treat short-stay, less complex cases and to avoid long-stay complex cases.

4. Because any change in services that will increase average length of stay or intensity of services will likely result in cost over a TEFRA limit, the system inhibits the development of new programs.

5. The process for administrative adjustment of limits does not provide a remedy because it is not timely (HCFA never decides cases within the period required by law) and does not recognize many legitimate costs.

II. The Proposal

This proposal has three elements: adoption of a prospective payment plan for rehabilitation based on Functional Related Groups (FRGs), as an interim step pending adoption of FRGs, rebasing of TEFRA limits to reflect current costs and expanding the conditions for exclusion from the PPS. Rebasing does not cure the principal defects of TEFRA -- the absence of adjustment of payment to reflect case mix and the distortions in costs and services produced by TEFRA limits. It is intended only to mitigate the worst financial inequities of TEFRA, pending early introduction of a PPS for rehabilitation.

The actions and analyses described below are budget neutral. This point is discussed below.

A. Prospective Payment For Rehabilitation

The rebasing plan outlined below will provide some temporary relief from a poor regulatory scheme. In any event, such adjustments are helpful, but do not remedy one point that is a fatal flaw of TEFRA: basing payment on the assumption that all patients in rehabilitation have the same requirements for service. Only a payment system that is based on appropriate classification of patients relative to anticipated duration and intensity of treatment will cure this defect.

In 1991, American Rehab. entered into a contract with the Department of Rehabilitation Medicine of the University of Pennsylvania Medical Center to determine the feasibility of developing a patient classification system for inpatient rehabilitation. That research produced a classification system, titled Functional Related Groups (FRGs). The system predicts length of stay in inpatient rehabilitation based on a combination of impairment group, functional motor, and cognitive status and age. The FRG system was developed with data from 58 hospitals and 69 units that contributed to the Uniform Data System (UDS) data base. The research team, headed by Dr. Margaret Stineman, was completing the final report in 1993.

Thus, a patient classification system for inpatient rehabilitation now exists. That system may be refined and improved, but the objective of creating a classification system that reasonably measures expected duration and intensity of treatment has been attained. There are 57 FRGs. A payment system based on patient classification would adopt the format of the Medicare PPS, substituting FRGs for DRGs. A rehabilitation hospital or unit would be paid a fixed amount per discharge based on a patient's FRG classification. Other adjustments used in the DRG system, for regional wage variations and disproportionate share, would also apply. The amount to be paid for a Medicare patient treated in a rehabilitation hospital or rehabilitation unit could be the product of the following calculation:

Standardized amount x FRG x wage index (applied to the wage portion) x disproportionate share (if applicable).

The two new elements in this calculation are the standardized amount and the FRG. A standardized amount would presumably be the average cost for Medicare discharges in a given period.

Beyond determining a standardized amount, a few other issues would need to be addressed. These include possible effects of underreporting differences between hospitals and units, transitional rules, and treatment of passthrough costs. The University of Pennsylvania is currently conducting research on the impact of co-morbidities on the FRGs and outliers. While there are some small variations for intensity of services per day, most of the differences among FRGs reflect lengths of stay.

American Rehab. is advocating adoption of the Functional Related Groups (FRGs) as a basis for Medicare payment for inpatient rehabilitation services while continuing to encourage research to enhance the predictive capacity of the system, including specifically the effect of co-morbidities and outliers.

B. Expanding Conditions for Exclusion

The current regulations setting forth the conditions for exclusion of rehabilitation hospitals and units from the Medicare prospective payment system require that 75% of inpatients require intensive rehabilitation services for 10 stated conditions. They are stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, arthritis, burns and neurological disorders. This regulation is based on data reflecting those conditions seen by rehabilitation providers in the late 1970's. The practice of rehabilitation medicine has changed considerably since that time, reflecting the impact of new technologies and survival rates. The proposal is to add four conditions reflecting the changes in the practice in the field over the time. The four conditions proposed to be added are cancer, pulmonary, cardiac and pain.

C. Modification To TEFRA

1. Rebasing

A rehabilitation hospital, long term hospital or rehabilitation unit currently having TEFRA limits would be assigned its Medicare cost reporting period ending on or after September 30, 1993, as a new TEFRA base year. Limits for subsequent periods would be determined based on per-discharge Medicare operating cost in this period.

2. Hold Harmless Incentive Payments, If Any

To protect incentive payments received in the new base year, a "hold harmless" provision would be added. Medicare payment per discharge in any subsequent period would not be less than the Medicare payment per discharge in the new base year (operating cost plus incentive divided by discharges) updated to the year in question.

3. Allowance for Facilities With Very Low Limits

Some rehabilitation hospitals and units have made radical changes in operations because of TEFRA, usually dramatically reducing lengths of stay through case mix changes and other means. This was necessary because the financial drain imposed by restrictive TEFRA limits offered no alternatives. Rebased limits for this group will continue to inhibit appropriate patient admission and treatment.

To address this problem, no rehabilitation hospital or unit would, in the rebasing process outlined

above, be assigned a limit that was less than 70% of the national average for its class of provider. The national average would be determined by HCFA from the most recent period for which data are available and updated to the rebasing year by appropriate TEFRA update factors. The 70% floor is proposed because any facility that is meeting the criteria for exclusion from PPS and Medicare coverage guidelines for treatment of rehabilitation patients cannot reasonably have costs much less than this amount.

4. Limits for New Facilities

Rehabilitation hospitals, long term hospitals and rehabilitation units excluded from the PPS on or after October 1, 1993, would continue to establish base years and TEFRA limits in accordance with present policy. However, Medicare operating cost per discharge in the TEFRA base year would not be recognized in calculating limits for subsequent periods to the extent to which it exceeded the estimated national average limit for its class of provider for that year by more than 10%. The estimated national average limit would be determined by taking the actual national average for the most recent period for which data are available subsequent to rebasing and updating it to the current year by TEFRA update factors.

The purpose of this limit is to restrict the potential for new providers receiving unlimited cost reimbursement while in direct competition for staff and patients with hospitals and units subject to TEFRA limits.

5. Full Market Basket Updates

The foregoing actions would inhibit potential increases in Medicare outlays for inpatient rehabilitation by eliminating the open-ended opportunity to create high TEFRA limits and the current ability of many providers to increase costs and be reimbursed 100% by the Medicare program. In recognition of these changes, rehabilitation should be exempted from any freezes or reductions in TEFRA updates and receive updates at the full market basket.

6. Budgetary Implications

The net effect of this proposal, if adopted, would be to reduce TEFRA limits for hospitals that are under their limits and raise limits for those that are over, subject to the points discussed in 2 and 3 above. Based on data for fiscal years ending in 1991 (the most recent data available from HCFA), this action would reduce the budget baseline for inpatient hospital rehabilitation services. The Federal budget baseline assumes that all providers are paid at their limits. This is logical since under current law they have the right to have reimbursement up to such levels, if and as costs are incurred.

Attachments 1 and 2 provide data on the collective position of rehabilitation hospitals, long-term hospitals, and rehabilitation units in the most recent reporting periods available from HCFA (mostly 1991). These data account for about 90% of providers in these categories.

Using the data on these schedules and the database from which they were drawn, the Federal budgetary effect of the actions proposed (using 1991 data) is as follows:

Costs over limits allowed by rebasing:	
1. Units	$109,900,000
2. Hospitals (rehab and long term)	$ 32,500,000
3. Total	$142,400,000

4. Less cost sharing over limits[1] (OBRA 90)	$ 44,400,000
5. Net increase from rebasing (line 3 - 4)	$ 98,000,000
6. Minimum Limit 70% of national average	$ 54,000,000
7. Retention of incentive payments	$ 52,000,000
8. Total cost of proposal (line 5 + 6 + 7)	$204,000,000
9. Offset from reduction of limits to cost (lines 9 - 8)	($224,600,000)
10. Net effect on Federal Budget	($ 20,600,000)

An allowance for administrative adjustment of limits is not included because there are no good data on this item. In any event, such adjustments are probably no more than the "net effect" amount shown above.

These calculations use data from cost reports ending approximately two years ago and current data would certain yield different numbers. It is reasonable to assume that the relationships of these factors would be similar in more recent periods.

III. The Schedule

Because not all hospitals and units now produce data on functional status of patients, it is assumed that perhaps two years will be required to introduce such a system. Over 50% of rehabilitation hospitals and units are now reporting data to the UDS and most others use similar systems. For the latter, conversion or adaptation would not be a major problem. UDS has already modified its data collection system to compute FRGs. In light of this constraint and the time required for consideration of this proposal, rebased TEFRA limits should be effective for two cost reporting periods beginning on and after October 1, 1994. Medicare reimbursement for periods beginning on or after October 1, 1996, should be controlled by a FRG-based system.

Submitted by,

Rob Schwartz
President and CEO

Attachments

[1] *The Omnibus Budget Reconciliation Act of 1990 provides for partial Medicare payment of cost over limits. The Medicare program now reimburses 50% of cost over the TEFRA ceiling to a maximum of 110% of such ceiling. The amount shown is that which would have been paid automatically under this provision and, therefore, is not additional cost associated with rebasing.*

ATTACHMENT 1

MEDICARE COSTS VS. TEFRA LIMITS OF LONG TERM AND REHABILITATION HOSPITALS

Total Hospitals Reporting	167
Under Limit	62
Over Limits	53
No Limits	52
Average Length of Stay (Under)	23.49
Average Length of Stay (Over)	25.44
Average Length of Stay (No Limit)	27.88
Average No. Medicare Days (Under)	13,137
Average No. Medicare Days (Over)	9,827
Average No. Medicare Days (No Limit)	7,406
Average No. Medicare Discharges (Under)	559
Average No. Medicare Discharges (Over)	386
Average No. Medicare Discharges (No Limit)	266
Average Cost per Discharge (Under)	$10,436
Average Cost per Discharge (Over)	$11,509
Average Cost per Discharge (No Limit)	$17,552
Average TEFRA Limit (Under)	$12,761
Average TEFRA Limit (Over)	$9,920
Average Cost per Day (Under)	$444
Average Cost per Day (Over)	$452
Average Cost per Day (No Limit)	$629
Average Medicare Cost Under Limits	$1,300,792
Average Medicare Cost Over Limits	$613,688
Total Cost Under Limits	$80,649,080
Total Cost Over Limits	$32,525,450

ATTACHMENT

MEDICARE COSTS OF REHABILITATION UNITS VS. TEFRA LIMITS

Total Units Reporting	618
Under Limit	276
Over Limits	328
No Limits	14
Average Length of Stay (Total)	20.7
Average Length of Stay (Under)	19.5
Average Length of Stay (Over)	21.9
Average No. Medicare Days (Total)	3,911
Average No. Medicare Days (Under)	4,117
Average No. Medicare Days (Over)	3,738
Average No. Medicare Discharges (Total)	189
Average No. Medicare Discharges (Under)	211
Average No. Medicare Discharges (Over)	171
Average Cost per Discharge (Total)	$10,217
Average Cost per Discharge (Under)	$9,355
Average Cost per Discharge (Over)	$10,942
Average TEFRA Limit (Total)	$10,431
Average TEFRA Limit (Under)	$11,827
Average TEFRA Limit (Over)	$8,982
Average Cost per Day (Total)	$490
Average Cost per Day (Under)	$480
Average Cost per Day (Over)	$500
Average Medicare Cost Under Limits	$521,615
Average Medicare Cost Over Limits	$335,066
Total Cost Under Limits	$143,965,460
Total Cost Over Limits	$109,901,640

Statement
of the
American Society of Internal Medicine
to the
Senate Finance Committee
on
Medicare and Health System Reform
April 12, 1994

Introduction

On behalf of the nation's largest specialty, the American Society of Internal Medicine (ASIM) is pleased to present it's views on Medicare and health system reform legislation. As the specialty that provides the greatest number of Medicare beneficiaries with primary and subspecialty care, the internists represented by ASIM–and their patients–have the greatest stake in any changes that Congress may make in the Medicare program. Internists are increasingly concerned that Medicare payment cuts and flawed payment policies are beginning to diminish access to needed services, especially primary medical care services. It is essential that as part of health system reform legislation, Congress address the current flaws in Medicare's payment policies. At a minimum, Congress must assure that overall system reforms "do no harm"–that is, any changes in Medicare payment methodologies, rates, coverage or benefits should not exacerbate the problems that are leading to diminished access to primary medical care and other services by internists. ASIM believes that Congress should enact health system reform legislation that:

1. **Provides universal coverage, while maintaining a pluralistic system of health care financing and delivery.** ASIM continues to believe that requirements that both employers and individuals contribute to the cost of health insurance coverage is the most feasible approach.

2. **Reforms discriminatory practices in the insurance industry.** Pre-existing condition exclusions must be eliminated in their entirety, and community rating must be mandated.

3. **Expands choice of physician and health plan.** Individuals should be able to choose from a wide menu of health plans, including fee-for-service plans. Properly constructed, purchasing groups or alliances can provide such wider choice. Purchasing groups should not have broad authority to regulate health care delivery, premiums, or fee schedules, or to exclude plans who are able to meet minimum standards (including solvency requirements, insurance market reforms, mandated benefits, and reasonable and non-intrusive data reporting requirements) from participation. All health plans should also be required to offer a point-of-service option, which would allow individuals to go outside the plan's physician and "provider" network, for covered services, *with reasonable limits on the cost-sharing that can be imposed when services are received on a point-of-service basis.*

4. **Puts physicians and patients in control of clinical decisions.** All health plans should be required to establish a participating physician review board, that would review and approve all utilization review criteria and methodologies, criteria for accepting or excluding physicians from the plan, quality review, appeals of reimbursement denials, and other issues that directly affect the services that physicians can provide to their patients. If health alliances are created on a mandatory or voluntary basis, and if they are given any authority over complaints about the quality of care provided within a health plan, appeals of health plan denials, and/or disclosure of clinical

data, then the alliances should also be required to establish physician and "provider" review boards that review and make recommendations on such clinical issues. Physicians who are nominated by state and national medical societies, including specialty societies, should be able to serve on the alliance governing board without running afoul of conflict-of-interest restrictions. If a national board or other national policy-making body is established that would have any degree of authority over clinical issues, then a parallel physician advisory board should also be created to review, advise, and make recommendations to Congress, the administration, the board, and the public on utilization and medical necessity standards, quality assurance methods and standards, benefit expansions or exclusions, and other issues that also determine the services that physicians are able to provide their patients. Physicians who are nominated by their professional associations should be guaranteed representation on any national board.

5. **Cost escalation should be restrained through competition between health plans, competitive pricing of physician services, liability reforms, practice guidelines, and negotiated and flexible spending targets, rather than through premium limits, fee schedule caps, rate-setting, or price controls.** ASIM believes that market-based reforms will be more effective in controlling costs, and will not engender the access and quality problems that inevitably will occur under more regulatory approaches. Internists support a deliberative process for reaching agreement on reasonable and predictable spending targets or goals, provided that the targets do not represent an absolute limit on spending, that they do not trigger automatic cuts in premiums or payments if the targets are exceeded, that they are established through agreement among the "stakeholders" rather than through an arbitrary and fixed formula, and that there is a process for reaching agreement on what should be done if the targets are exceeded, which could include agreed-upon targeted interventions to restrain cost increases or changes in the targets if it turned out they were not realistic after all. Efforts to restrain cost increases should address such factors as patient demand for new technologies, defensive medicine caused by this country's wasteful and litigious liability system, and administrative costs that result from intrusive and unnecessary government regulations. All current and proposed government regulations affecting medical care should be submitted to a rigorous cost-effectiveness analysis, and withdrawn or modified if such analysis shows that the compliance costs exceed the presumed benefits. Approaches that rely on excessive bureaucracy should not be accepted.

5. **Achieves real liability reform, including a cap on non-economic damages and a sliding scale limit on attorney's fees.** The Office of Technology Assessment recently released a report that concluded that a cap on non-economic damages is one of the few reforms that have been shown to lower liability costs. Health system reform legislation that fails to deal with the massive inefficiencies and costs created by our current tort system will not succeed in controlling costs, eliminating unnecessary procedures, and improving quality.

6. **Provides fair compensation for all physicians' services, but especially primary medical care services provided by internists and other physicians.** As explained later in this statement, access to primary medical care is likely to be diminished further unless steps are taken now to improve payments for primary medical care services, to reduce the regulatory burden placed on primary medical care and other office-based physicians, and to redirect training programs to produce a more desirable mix of generalists to specialists.

7. **Does not rely on Medicare as a source of financing for health system reform. If Medicare spending is capped or reallocated to support broader reforms, it is essential that primary medical care services be protected from further reductions. Because of flaws in Medicare payment methodologies, Congress should not mandate the Medicare rates or methodologies for all payers.** ASIM specific views on Medicare are discussed in the remainder of this statement.

8. **Requires individuals to contribute to the cost of their own medical care, through appropriate co-insurance and deductibles. Individuals should also be given the option of "self-insuring" their basic medical care by allowing them to establish tax-free medical savings**

accounts, with insurance to cover catastrophic expenses above a specified level. The medical savings accounts should be offered as an option, along with a wide choice of managed care, fee-for-service and other insurance options. Appropriate cost sharing requirements are necessary to give everyone a financial stake in the services that are provided to them. Medical savings accounts would be an attractive and viable option for some individuals but not for others. Individuals should be able to decide whether or not they should establish a medical savings account or enroll in more conventional insurance programs.

Incorporating Medicare into Broader Reforms

ASIM does not favor incorporating Medicare *at this time* into broader health system reforms. Until more experience is gained in the reforms affecting other Americans, it is premature to dismantle a program that is generally successful in providing adequate access to care (despite the growing problems discussed below) in favor of an untried system. Ultimately, however, ASIM believes that it would be appropriate for patients now enrolled in Medicare to receive their medical care under the same delivery and financing systems as all other Americans. This should occur only after sufficient time is spent evaluating and making improvements in the broader-based reforms, and must be done in a manner that does not disrupt or adversely affect the benefits or access to care for the Medicare population. In the interim, Congress can enact policies that will make it easier to incorporate Medicare patients at a later date into the broader based reforms, such as by improving problems in Medicare payment policies that result in Medicare payments being considerably below private sector payments, and by making changes in the methodologies used in the private sector payments that will make them more consistent with the resource based relative value scale (RBRVS) used by Medicare, but without mandating the Medicare payment rates or other flawed payment policies. Our views on this are discussed later in this statement.

Improving Medicare Payments for Primary medical care Services

As Congress considers proposals to reform the health care system, it is essential that it address not only the lack of insurance coverage for many Americans, but other factors that reduce access to needed services. More specifically, if access is to be assured, then the growing economic and environmental obstacles to the provision of primary medical care services must also be addressed. Expanded insurance coverage cannot, by itself, guarantee access to essential medical care if the economic policies make it impossible for physicians to provide primary medical care services.

Already, many patients are experiencing problems in obtaining needed primary medical care services. The Physician Payment Review Commission, in its 1994 report to Congress, noted that although Medicare beneficiaries "generally" are not experiencing access problems, several recent surveys found that when access problems are encountered, they usually involve primary medical care services. The commission's report discusses the results of two commission surveys, one being a comprehensive mail survey of all 540 congressional offices, and the other being a brief mail-in questionnaire included in the November, 1993 AARP Bulletin. The commission notes that "such data may *underrepresent* the true scope of any access problem, particularly for vulnerable populations. . . " (emphasis added by ASIM). Even with the acknowledgement that the surveys in all probability underrepresent the growing difficulties encountered in obtaining access to primary medical care services, they do support the conclusion that access to primary medical care is at risk for a growing number of Medicare patients. More specifically, the commission found that " . . . access problems centered around primary care physicians. Of congressional offices that mentioned physician specialty, more than half the responses were for family practice, general practice, and internal medicine physicians. In the AARP survey, problems in finding primary care physicians were noted in 60 percent of responses. In most cases, beneficiaries were trying to find a new primary care physician after moving or after their previous physician had moved or retired. The finding that primary care is the center of beneficiaries' access complaints is re-enforced by recent physician surveys. The commission's 1992 survey of physicians found that 10 percent of

primary care physicians were not accepting new Medicare patients, versus 3-4 percent for other specialties. Similarly, a 1992 American Medical Association (AMA) survey found that 9 percent of primary care physicians were accepting no new Medicare patients, versus 4 percent for other physicians. Other survey results indicate the problem may even be larger." A footnote in the commission report notes that the AMA survey found that less than 70 percent of primary care physicians, versus 80 percent for other physicians, were accepting new Medicare patients. In a 1992 survey of members of the American Academy of Family Physicians, 28 percent reported not accepting new Medicare patients.

ASIM has not conducted its own formal survey on internists' willingness to accept Medicare patients. The letters and calls from our members, and anecdotal reports presented at ASIM meetings, suggest that a substantial and growing number of internists who provide primary medical care do not accept new Medicare patients, and for those who do accept Medicare, it is increasingly difficult to provide them with the services that they need for Medicare payment rates that are only 59 percent or less than private sector payments for comparable services.

The commission's data on the impact of the Medicare fee schedule support the view that it is not creating adequate incentives for primary medical care. Despite the fact that internal medicine is the specialty that more Medicare patients depend on for primary medical care than any other, the commission reports that from 1991-1993, Medicare payments per internist *decreased by two percent* and total Medicare revenue per internist *dropped by six percent*. Ironically, the drop in total Medicare revenues for internists was the same as the decrease for ophthalmology, and only slightly less than the decrease in total Medicare revenue for surgery (eight percent). These data do not include cardiology or gastroenterology in internal medicine. Medicare revenues for internists decreased by a greater amount than was the case for radiology and urology, both of which experienced zero reductions in Medicare revenue. Thirty-seven percent of *non-procedural* internists experienced reductions of five percent or more in Medicare payments.

Ironically, even though Medicare payments for internists increased by a small amount, these increases were more than offset by reductions in the volume and intensity of services rendered by internists. *Internal medicine was the only specialty that had a net reduction (four percent) in the volume and intensity of services provided to Medicare patients.* Because internists were more successful in reducing volume, they have been penalized with less Medicare revenue, while the other specialties that increased volume and intensity were rewarded with more revenue. This is exactly the opposite of what should have occurred under any rational payment system.

Given the unmistakable conclusion that the Medicare fee schedule and related payment policies are lowering payments for the specialty that provides primary medical care to more patients then any other, there should be little question about why more patients are having difficulty finding physicians who provide primary medical care, why more and more physicians are not accepting Medicare patients, and why it is essential that Congress act now to correct the problems that are discouraging physicians from entering into–and remaining in–primary care.

ASIM believes that the trend toward reduced access to primary care is likely to worsen if private sector and governmental economic and regulatory policies continue to create disincentives for the provision of primary medical care services. Despite efforts to improve payments for primary medical care services, it is apparent that public and private sector health insurance programs continue to undervalue primary medical care services. The data presented above show that the Medicare fee schedule, which was supposed to create incentives for primary care, has not accomplished what was intended. Medicare budget cuts, and differential fee schedule updates that have provided larger annual increases for services other than primary medical care services, have undermined the intended improvements for primary care. Because the Medicare fee schedule and related policies are increasingly being adapted by private insurers, Medicare's flawed policies have an impact that affects far more individuals than the patients enrolled in the program. At the same time, the regulatory costs and hassles associated with providing primary

medical care services has increased. Unless Congress takes action now to address the financial disincentives for primary medical care services, more Americans are likely to experience difficulties in obtaining needed primary care.

Recommendations to Create Incentives for Primary medical care

At a minimum, ASIM urges Congress to adopt the following policies to create economic incentives for primary medical care--and to forestall policies that would do further harm to primary care:

1. Congress should mandate substantial increases in Medicare payments for primary care services--defined by law as office, nursing home, home, and emergency room visits--as part of health system reform legislation. The increases should be at least as great as those called for in the President's Health Security Act (HSA).

The HSA proposes to increase payments for primary care services in a budget-neutral manner by redistributing relative value units (RVUs) from certain other designated services. Since concerns have been expressed by some that Congress should not legislate changes in RVUs that could "distort" the resource based relative value scale (RBRVS), it would be appropriate to mandate bonus payments for primary care services that are at least equivalent to what would be achieved by the HSA. These bonus payments should be applied to primary care services rendered in all localities, and should be added to the fee schedule payment at the time that primary care services are reimbursed. Budget neutrality could be maintained by offsetting the costs of the primary care bonus by lowering the fee schedule conversion factor for all other services. HHS should also support further research to determine if the existing RVUs for primary medical care and other evaluation and management services are adequate. The 1994 PPRC report expresses support for bonus payments for primary care services as an alternative to the HSA's proposed changes in RVUs.

2. Congress should mandate a 1995 fee schedule update for primary medical care services that is at least equivalent to, or higher than, the update for other categories of services. It should not allow the current law update, which would provide a lower increase for primary medical care services than other services, to go into effect by "default."

Primary medical care services are disadvantaged under the volume performance standards (VPSs) that will determine the 1995 "default" update. Unless Congress acts to change the default update, it appears that surgical procedures will receive a much higher update than primary medical care services. This would represent the third consecutive year in which primary medical care services received a lower update than surgical procedures. As long as primary medical care services continue to receive lower updates than other services, the payment inequities that discourage physicians from providing primary care will grow. Further, as long as surgery continues to receive annual increases that are greater than for primary medical care, Congress' and the administration's commitment to primary care will continue to be doubted by most primary care physicians. ASIM appreciates the strong stance taken by the Finance committee last year in support of a full update for primary care services, which was included in OBRA 93. We recognize that this was accomplished despite formidable opposition from some in Congress and from some physician groups. Although this clearly was a positive step, it must be recognized, however, that surgical procedures still received a higher update than primary medical care services.

3. Congress should reject the administration's proposal to replace the current VPS formula with a fixed target based on per capita growth in gross domestic product and to eliminate the floor on the default "update" for all services. Congress, the administration, and the Physician Payment Review Commission, in consultation with medical organizations, should develop alternatives that would guarantee adequate updates for primary medical care services.

In 1993, Congress enacted legislation, as part of OBRA 93, to create a separate VPS for primary care services. The intent was to correct the flaws that disadvantage primary medical care compared to other services. Unfortunately, however, Congress also made the VPSs for all categories of services (primary care, surgery, and "other" nonsurgery) more stringent, and lowered the floor on the default update (minimum update) for all services. The effect of these changes, which will determine the default updates beginning in 1996, will be to make it more difficult to keep spending within the VPSs, while at the same time lowering the minimum update that would be guaranteed by law. The likely result will be lower updates for all services, including primary medical care.

The administration has now proposed to make the VPSs even more stringent, and to eliminate entirely the floor on the annual updates. The Physician Payment Review Commission has concluded that these changes are likely to result in annual *negative updates*–that is, absolute reductions, in payments–for all services, including primary medical care, beginning in 1998. It also projects that this will widen the gap between Medicare's payment rates and those of other payers. Medicare currently pays only 59 percent of private sector rates, and the gap has widened in recent years. Although the administration has proposed an additional allowance for the primary care VPS, this is likely to be insufficient to protect those services from being reduced. The administration proposal would also have a disproportionately adverse affect on hospital visits, consultations, and procedures provided by physicians who also provide primary medical care services.

Congress should reject the administration's proposal, and develop alternatives that would guarantee fair and adequate updates for primary medical care services. Consideration should be given to providing a lower "performance standard reduction" factor for primary care services than for other services, as the Senate Finance Committee proposed to do last year, and to providing a separate and higher minimum default update (floor) for primary care services. We greatly appreciate the support that this committee gave last year to the separate VPS for primary care services and the lower performance standard reduction for this category, even though the latter was not enacted.

4. Congress should mandate that HHS develop resource based practice expense relative value units, and implement them no later than January 1, 1996. Interim measures to increase undervalued practice expense RVUs should be considered.

The PPRC, HCFA, the Harvard group that developed the RBRVS, most physician groups and outside experts agree on one thing: the current charge-based methodology remains one of the biggest flaws in the Medicare fee schedule, and is among the principal reasons that primary care visit services, and other evaluation and management services, continue to be undervalued by the fee schedule. Last year, Congress mandated reduced payments for practice expense RVUs it considered to be overvalued, but did not mandate a change in the methodology for undervalued services, or interim increases in payments for those services. A proposed mandate that HHS develop a resource based practice expense methodology was unfortunately dropped from OBRA 93 on procedural grounds (the "Byrd" rule). We appreciate the fact that the Finance committee did support the resource based practice expense mandate in its version of the budget reconciliation. The fact that the current methodology, which greatly disadvantages primary medical care, remains intact is a source of great concern to internists. We believe that it essential that Congress mandate a correction, that it do so without delay, that it require that it be implemented as early as possible, and that it authorize HHS to implement the new methodology without having to get approval again from Congress. We are concerned that unless Congress acts now, this necessary change will continue to be stalled within HHS over policy disputes and arcane technical grounds. The problem is <u>not</u> that the data to accomplish this can't be produced, or that an appropriate methodology can't be developed, or that this can't be done anytime in the near future–all excuses that have been used in the past by some to forestall action. If Congress mandates that this be done, we believe that it can be implemented by 1996 in a methodologically-

defensible manner. Further, Congress should consider making interim increases in undervalued practice expense RVUs to move payments toward the desired goal.

4. Congress should reject proposals to mandate equivalent payment rates for Medicare and private payers or to mandate the Medicare payment methodologies for all payers.

Because of the flaws discussed above, the Medicare fee schedule and related payment policies should not be applied to private sector rates. Reducing private sector payments to the Medicare rates will be particularly detrimental to primary medical care services that are already undervalued in private and public sector fee schedules. Alternatives that would move toward greater consistency in public and private sector payment policies merit consideration, provided that they create adequate incentives for primary medical care and do not lock in existing inequities. Because of the inequities in Medicare payment policies, the Medicare fee schedule is not an acceptable basis for achieving greater uniformity and consistency.

5. Congress should not prohibit balance billing under Medicare and other programs. Instead, it should institute measures to use market forces to bring about competition and predictability in payments and fees for physician services.

A prohibition on balance billing under Medicare will reduce the already low payment rates under this program, which will be especially disadvantageous to primary medical care. Further, balance billing limits under Medicare and other programs represent a form of price controls, which in turn will introduce distortions and undesirable changes in medical practice. The experience to date with the Medicare fee schedule, which has fallen far short of what was expected by Congress when it mandated the reforms, indicates why Congress must tread carefully before moving toward fixed fee schedules, with no balance billing, for other payers. ASIM's competitive pricing proposal, discussed in the next section, presents a better way to provide individuals with the information needed to predict their out-of-pocket expenses, and to bring greater uniformity and predictability into private sector payments, without the problems created by balance billing limits.

Introducing Competitive Pricing for Physician Services

As an alternative to balance billing limits, fixed fee schedules, and all-payer rate setting, ASIM has for the past two years been advocating an innovative proposal to introduce greater uniformity and price competition into fees for physician services. Our "competitive pricing" proposal has since won the support of noted Princeton economist Uwe Reinhardt, a member of the PPRC; Business Week magazine, which endorsed it; and the AMA. It is a feature of the reforms enacted last year by the state of Maryland, and has received positive commentary in the PPRC's 1994 report. ASIM's proposal would create a simple yardstick for patients to compare the fees charged by physicians and the payments for fee-for-service health plans. It does not require that patients research the fees charged by physicians, or depend on unworkable approaches like posting of fees in physician services. Instead, it would give all patients a chart that easily presents the percentage differences between each physician's charges and their plan's allowed payments.

Here's how it would work. Congress would mandate that all physicians and fee-for-service payers use an expanded and improved RBRVS, similar to the one used by Medicare (but without Medicare's conversion factor, VPSs, and other flawed policies), to establish their own annual charge and payment schedules. Improvements would be made in the RBRVS, such as basing the practice expense RVUs on resource costs. On an annual basis, each health plan would select its own dollar conversion factor (multiplier) for the RBRVS, based upon what it believes would be competitive in the community. Each physician (or in the case of a physician group that billed under the same provider number) would similarly select their own annual conversion factor. The insurer's conversion factor, each physician's conversion factor, and the percentage difference between the conversion factors of each physician and the health plan would be calculated, and provided (by the insurer or employer) in a directory to individuals enrolled in the health plan.

(Alternatively, a purchasing group, health alliance or state agency could compile the information and publish the directory).

With this information, a patient could easily determine if a physician's charge for covered services is the same as the insurer's allowed payment schedule, and if not, how much higher (by percentage difference) the physician's charges would be. They would be able to compare how each physician's charges compare with all other physicians within the same specialty in the same community. The patient could choose a physician who exposes them to little or no out-of-pocket costs (one who has the same conversion factor as the insurer), or a physician who charges more, if the patient felt that the services provided by the physician with higher fees were worth more. Physicians who charged more than what most insurers' allowed would have a strong incentive to lower their conversion factor, unless they can demonstrate to patients they are worth more.

This system would end the "black box" that now exists for patients: patients do not now have access to what their insurer allows toward covered services, they do not know what the physician charges, and their is no easy way to compare the charges of one physician compared to another. For the first time, they could reliably predict their maximum out-of-pocket expenses due to balance billing. And, for the first time, real price competition would be introduced into physician services. Further, by using an RBRVS similar to Medicare's, it would create incentives for primary medical care and move private sector payments in the same relative direction as Medicare's fee schedule, which are necessary pre-requisites to including Medicare patients in the broader system reforms. But it would not lock physicians and health plans into the low and inequitable payments created by Medicare's conversion factor, balance billing limits, and volume performance standards.

The PPRC's 1994 report to Congress (p. 68 of the report) describes the ASIM proposal, saying that "To limit their financial liability, consumers would be able to use this information (comparisons of the conversion factors in "an easy-to-understand format") to select physicians whose conversion factors would result in low balance billing. Physicians would thus face market pressures to select conversion factors that were competitive with their colleagues. Rather than through government rules, consumers' financial protection would be met through their selection of providers." Because of the merits of this approach, the commission included it as "one key feature" in its recommended policy on balance billing. It proposes to require physicians to disclose their balance billing percentage on annual basis. The commission departs from the ASIM approach, however, by still insisting that an upper limit on balance billing should be imposed. ASIM strongly believes, however, that if patients have access to comparative price information in an "easy-to-understand" format--as the commission acknowledges our proposal would do--there is no need to impose a limit on balance billing. The logic of the commission's belief that balance billing limits would still be required escapes us. Further, if experience with the competitive pricing approach found that some patients were exposed to unaffordably high fees, despite the price competition that would be introduced, Congress could always revisit balance billing limits.

Dr. Reinhardt, in an article published in the April 25, 1993 issue of Roll Call, states that "the high price transparency alone would probably drive health care prices toward greater uniformity and acceptable levels, even without explicit rate regulation." He also argues that "if doctors used the same list of procedures and all hospitals likewise, many billions of dollars now spent on paperwork could be saved." For a Congress that is seeking maximum administrative savings to finance reform, and that it looking for ways to restrain inappropriate price increases without rate regulation–and for patients who are looking for an easy way to predict out-of-pocket expenses–the appeal of ASIM's competitive pricing proposal should be obvious. We strongly urge the Finance committee to support this innovative approach instead of fixed fee schedules, balance billing limits, or mandating the Medicare rates and methodologies for all payers.

Workforce Reforms

In addition to creating economic incentives for primary medical care, ASIM continues to believe that a national physician workforce policy, that would encourage a better distribution of generalists to specialists, is needed. We have endorsed Senator Rockefeller's Primary care Workforce Act of 1993 to establish such a policy, with some suggestions for improvements in a few specific provisions. ASIM disagrees with those who believe that the market can itself correct the problem. We specifically believe that workforce legislation should include the following:

1. Requirements that all payers pay into a pool to fund graduate medical education (GME).

2. A goal that at least 50 percent of physicians be trained in general internal medicine, family practice, and pediatrics. In working towards this goal, care must be taken that the quality of scientific training is not sacrificed in the effort to achieve greater numbers of generalists. We strongly believe, however, that this should be a goal, not a rigid quota. A national commission, as described below, should have the flexibility to recommend policies that may differ somewhat from the goal, provided that those policies are consistent with the objective of increasing the proportion of generalists compared to other specialties. The workforce policy should take into consideration the role played by internist-subspecialists in meeting the primary medical care needs of the country.

3. A national commission, with adequate representation from practicing physicians, including primary care physicians, to advise Congress and HHS on the workforce policy.

4. Enforcement of the workforce policy by changes in GME payments to residency programs.

5. Increased training in appropriate ambulatory settings without sacrificing the quality of scientific training.

6. A cap of 110 percent on total training positions.

7. A timetable for implementation that achieves that changes as quickly as is feasible, without disrupting medical students and physicians who are currently in training.

We look forward to working with the committee on legislation consistent with these principles.

Other Issues

There are several other issues, not necessarily related to Medicare, that we would like to address. ASIM is concerned about the direction and specifics of several of the recommendations in the PPRC report. We believe that the report is excessively oriented toward regulatory approaches to health system reform. Ironically, the commission opposed regulation on one key issue--requiring that all health plans offer a point-of-service option--where regulation is needed. Specifically:

1. For the reasons discussed earlier, we fundamentally disagree with the PPRC's support for expenditure limits and fixed fee schedules with no balance billing.

2. We disagree that health plans should be able to "voluntarily" offer a POS plan but should not be required to do so. Since market forces are pushing more Americans into plans that restrict choice of physician, it is essential that all plans offer an "escape valve" so that patients can go outside a health plan's network for specific services. The POS plans now being offered voluntarily by the industry typically impose punitively high cost-sharing on individuals who exercise this option, and/or restrict them to obtaining primary medical care services only from the plan's physician and "provider" network. Offering individuals a choice of only one POS plan, which is the commission's preferred alternative to mandatory POS, is inadequate, since this could

force individuals to choose an otherwise inferior plan simply to obtain the choice provide by a POS plan. They should instead by able to choose the best plan that meets their need--and be able to pay a little more to go outside their chosen plan's network when they decide it's necessary. Further, if the cost-sharing imposed by the single POS plan is excessive, very few individuals may be able to afford to use this option. If choice is to be available to individuals other than the wealthy, it is imperative that Congress mandate that all plans offer POS, that the cost-sharing difference for the POS option be set at a reasonable limit, and that plans be prohibited from requiring that individuals obtain primary medical care and preventive services from the network.

3. We disagree with basing the Medicare VPSs on changes in gross domestic policy (GDP) and making it cumulative. ASIM does agree though that if this change is made, it should be done in a budget neutral manner, as the commission recommends.

Conclusion

Amenca's internists remain committed to working with Congress to enact comprehensive reform that guarantees coverage to a standard benefits package, that reforms the insurance industry, that offers the widest possible choice of health plan and physician, that puts physicians and patients in control of patient care, that makes real reforms in the medical liability system, that relies on competition and professionally-developed practice guidelines to control costs rather than expenditure limits and price controls, and that makes improvements in Medicare's flawed payment policies, especially those policies that disadvantage primary medical care. We look forward to working with the committee in producing a bill that is consistent with the objectives and the recommendations in this statement.

STATEMENT OF THE GROUP HEALTH ASSOCIATION OF AMERICA (GHAA)

Good morning. I am George Halvorson, CEO of HealthPartners HMO in Minneapolis, and chairman-elect of the Group Health Association of America (GHAA).

HealthPartners is a 600,000-member, consumer-governed, nonprofit HMO that includes Group Health, Inc., a staff-model HMO, and MedCenters Health Plan, a group-model HMO. HealthPartners currently has over 16,000 Medicare beneficiaries enrolled in our Medicare risk contract, and almost 6,000 Medicare beneficiaries enrolled in our Social HMO.

I am here today testifying on behalf of GHAA, which represents 350 health maintenance organizations (HMOs) with 33 million members who account for about 75 percent of total HMO enrollment nationwide. Almost 90 GHAA member plans have risk contracts with the Medicare program. This represents 77% of plans that participate in the program and 92% of the enrollment in the program. Our members also participate in the program under cost-based contracts.

HMOs, Medicare, and Health Care Reform

I am pleased to be here to talk about the role of HMOs in the Medicare program both today and in the future as health care reform takes place. In the course of my testimony, I will address the five following major areas:

- the advantages of HMO membership for Medicare beneficiaries;
- policies needed to retain and expand HMO membership as an option for Medicare beneficiaries in the future;
- problems with the current Medicare risk reimbursement system;
- S. 1996, Senator Durenberger's bill to improve the Medicare risk contracting program; and
- provisions of the Administration's health care reform proposal that would impact HMO Medicare contracting.

Background

HMOs are care systems that deliver that care through teams of health care professionals. Their primary goals are keeping their members well and providing high-quality, coordinated health care. Consumers consistently give HMOs positive reviews, which are reflected in high enrollment renewal rates. In fact, HMO enrollment has quadrupled during the past decade alone based almost entirely on consumer choice. Today, about 45 million people -- *roughly one out of every five Americans who have health insurance -- are enrolled in HMOs*, and GHAA estimates that HMO enrollment will exceed 50 million by the end of

1994. The vast majority of these HMO members selected their plans in an environment of choice -- they chose to be our members.

What is it about HMOs that makes them attractive? HMOs organize the delivery of comprehensive health care services in a way that makes a great deal of sense to many Americans. The benefit packages we offer tend to be significantly broader and more complete than those offered by indemnity insurers. Out-of-pocket costs are invariably lower. Typically, HMO members benefit from being able to select a personal physician within each health plan who knows their needs and can coordinate any specialty care the members may require. Our members also benefit from predictable, low out-of-pocket costs, and they are not burdened by the need to file claims forms to take advantage of covered benefits. In fact, the administrative systems in many of our plans are much less costly than typical insurance administration in this country -- and many plans incur administrative costs that are, in fact, lower than those incurred in single payer systems like Canada.

HMOs promote quality in many ways, including careful selection of providers based on professional qualifications, and interest in working within a coordinated system. Eighty-five percent of HMO physicians nationwide are board-certified, compared to only 60 percent of physicians nationwide. We routinely monitor and analyze ambulatory clinical practices to improve the quality of the delivery system and cost-effectiveness of care in ways that are not available or possible for traditional health care insurance arrangements.

Many policy makers think of HMOs as an urban or suburban phenomenon. In fact, HMOs have a successful track record in rural communities. In 1990, 301 HMOs served both urban and rural counties, and 15 more served rural counties only. Involvement is growing as doctors, consumers, and administrators find new ways to adapt HMO models to meet the unique needs of rural areas.

Let me speak for a moment about our own health plan. Our plan, for example, has made a commitment to reduce the incidence of heart disease, diabetes, preterm births, and several other key conditions by 25 percent over the next four years. That type of commitment to real health is only possible in an HMO environment.

Current HMO Participation in the Medicare Program

Under current law, HMO have three options under which they may contract with the Health Care Financing Administration (HCFA) to provide Medicare covered benefits to Medicare beneficiaries. These options are:

- contracting as health care prepayment plans (HCPPs) on a cost basis to provide some or all of the Part B services;
- contracting as federally qualified HMOs or as competitive medical plans (CMPs) on

a cost basis to provide all Part A and Part B services; and

- contracting as federally qualified HMOs or as competitive medical plans (CMPs) on a risk basis to provide all Part A and Part B services. Under this option HMOs are paid based on prospectively determined rates that are intended to reflect 95 percent of the amount HCFA would have paid if the beneficiaries enrolled in the HMO had remained in the fee-for-service Medicare program (95 percent of the adjusted average per capita cost [AAPCC] of providing the covered benefits).

As of March 1, 1994, approximately 600,000 Medicare beneficiaries were enrolled in HMOs with HCPP contracts; 162,000 Medicare beneficiaries were enrolled in HMOs with cost contracts and almost two million Medicare beneficiaries were enrolled in HMOs with risk contracts.

Advantages of HMO Membership for Medicare Beneficiaries

Medicare beneficiaries are already realizing some of the central goals of health care reform. They have access to affordable, high quality, comprehensive benefits in exchange for a fixed monthly premium. Medicare HMO members receive all Medicare covered benefits but in addition, they also have access to comprehensive coverage at affordable and totally predictable cost.

This is possible because under the risk contracting program, HMOs return to the beneficiaries in the form of added benefits any difference between 95 percent of the AAPCC (intended to represent the fee-for-service cost of providing the Medicare benefits) and the premium the HMO would need to provide Medicare covered services. Beyond the benefits HMOs can provide with the "savings" generated by cost-effective care, most HMO Medicare risk contractors also add benefits that make Medicare beneficiaries' coverage closer to the comprehensive benefits offered to other HMO members.

Over 42 percent of Medicare beneficiaries are charged premiums for their HMO coverage of less than $20 per month. Almost half of premiums for these coverages cost less than $50 per month. The HMO premium includes the Medicare enrollee's Medicare deductibles and coinsurance. This means that these Medicare out-of-pocket costs are translated into a predictable amount per month, rather than being imposed at the time of service.

Indicative of the importance of preventive services to HMOs is the fact that over 97 percent of plans cover routine physicals; almost 90 percent cover immunizations; over 80 percent cover eye exams; and 65 percent cover ear exams, which are not otherwise covered by Medicare. Other services included by HMOs include health education, outpatient drugs, foot care, and dental services. Over one-third of HMOs with Medicare risk contracts include an outpatient prescription drug benefit, a benefit that is highly valued by seniors.

The positive impact of HMO enrollment on the health care of Medicare beneficiaries was

documented in a study published by Mathematica Policy Research, Inc., last December. The study demonstrated the benefits of Medicare beneficiaries' receiving coverage through HMOs. These benefits included increased access to care; quality of care that is at least the same, and in many cases superior to fee-for-service care -- while using fewer resources; an increased range of choices for beneficiaries; more coverage at lower costs; high member satisfaction; and a potential to generate Medicare program savings.

The study found that about 90 percent of HMO members rated their HMO care as good or excellent. Members were particularly satisfied with the plans' affordability. Fourteen of fifteen HMO members would recommend their HMO to a friend or family member. This is a key indicator of satisfaction with health care. Many other studies also illustrate HMOs' record of quality.

- A study published in *Medical Care*, for example, showed that "For five of six (cancer) screening tests examined . . . members of HMOs are significantly more likely to have received the test within the last three-year period." (*Medical Care*, 1991)

- Another study comparing treatment decisions among 140,000 Californians with clogged coronary arteries found that HMOs offer the best way to avoid unnecessary medical treatment without sacrificing needed care. (*New England Journal of Medicine*, December 9, 1993)

In addition, Medicare risk contracting HMOs serve a disproportionate number of low-income beneficiaries. HMOs reduce financial barriers to care -- annual out-of-pocket costs for the average HMO member are $600 less than in Medicare fee-for-service -- including the HMO premium. HMOs therefore protect beneficiaries from catastrophic financial costs. HMOs do not impose lifetime maximums or spell of illness limitations on benefits. Medicare risk contracting HMOs provide an affordable choice for comprehensive coverage to low-income elderly -- those unable to afford insurance industry Medigap premiums and significant, unpredictable, out-of-pocket costs.

Foundation for Expanding HMO Participation in the Medicare Program

As the health care reform debate moves forward, decisions will be made about the impact of reform on the Medicare program and whether to include the program in any restructuring of the nation's health benefits marketplace. We believe Medicare beneficiaries should have a chance to choose among delivery systems. Expansion of the availability of HMO membership will be an important aspect of this right to choose.

GHAA believes that existing Medicare contracting opportunities for HMOs -- although they can and should be improved -- have created a solid foundation for the future. From this experience several elements can be identified that will be important to fostering future

HMO participation in the Medicare program, regardless of its treatment in the context of health care reform.

These elements include the following:

- Maintain the opportunity for HMOs to receive capitation, so that care will not be compromised and constrained by the inherent limitations of the traditional Medicare fee-for-service payment approach.

- Permit HMOs to offer a broader benefit package than Medicare covered benefits. HMOs emphasize preventive care, early intervention, and coordination of care in order to provide high-quality, cost-effective services. If they were required to offer benefits limited to the Medicare benefit package, they would lose the capability to cover services that are essential to meeting these goals. (We, for example, have cut the readmission rate for seniors with congestive heart failure in half with a special program that involves putting special scales in their homes and having nurses call each patient daily to check on their weight and health status. That program has significantly improved the health status of the seniors involved, and it reduces costs -- because it reduces hospitalizations. That program, and others like it, would not qualify for reimbursement under traditional Medicare fee-for-service payment. Medicare only pays for sick people, not for keeping people well.)

- Retain HMOs' ability to enroll Medicare beneficiaries outside the risk contracting program. It is difficult for HMOs with small numbers of members to absorb the random cost of illness for Medicare beneficiaries. For some HMOs, current cost-based reimbursement mechanisms provide an opportunity to gain experience in meeting the special needs of Medicare beneficiaries without incurring the significant financial risk that can accompany risk-based reimbursement.

- Improve the highly flawed and inconsistent reimbursement mechanism in the current Medicare risk contracting program, which is currently based upon the adjusted average per capita cost (AAPCC) calculation.

- Assure Medicare beneficiaries a choice among health care delivery systems, including both HMO or other managed care offerings and fee-for-service coverage.

Improvements in the Medicare Risk Contracting Program

Despite the overall growth in the number of people in the U.S. who are receiving their health care through HMOs, there has not been parallel growth in the number of Medicare beneficiaries enrolled in HMOs. This has been primarily due to a relatively low level of HMO participation in Medicare -- and not due to consumer reluctance to join HMOs. Consumers join HMOs where they are offered. Only one-fifth of plans are currently

participating in the program. They serve around four percent of Medicare beneficiaries nationally.

Inadequate capitation rates are the major reason for the relatively low participation of HMOs in risk contracts, and thus the low rate of growth in program enrollment. Such inadequate rates are a particularly serious barrier to participation in rural areas. Key problems are:

- The rates are unstable from year to year, which makes planning difficult, if not nearly impossible, for HMOs.

- The rates are not sufficiently risk adjusted to reflect the risk mix across different contractors.

- The geographic area on which the rates are based is the county in which the beneficiary resides. Counties do not adequately reflect patterns of health care services or health plan market areas. Rates in adjacent counties vary significantly and haphazardly. The only consistency seems to be an inadvertent discrimination against rural counties and areas where the health care providers are cost efficient.

- The rates are tied to the traditional fee-for-service costs in a given area, and not to HMOs' costs of providing health care. One very interesting fact that you should consider carefully is that the AAPCC tends to be significantly lower in areas that have high HMO enrollment because of the "spillover effect." This makes perfect sense. Physicians who have adopted a more efficient practice style, because of participating in HMOs are likely to practice the same style of care with their fee-for-service patients. That change in behavior reduces fee-for-service costs and, because of the AAPCC formula's link to fee-for-service that efficiency reduces AAPCC rates as well. In other words, the payment approach creates a penalty for efficiency. It is hard to argue that that's good policy.

GHAA has developed a list of general principles that should be used to evaluate proposals for new or revised Medicare risk payment methodology. The method should:

- be perceived as being objective and fair, and support efficiently operating delivery systems, even when the systems enroll populations that consume substantial health care resources;

- result in relatively stable and predictable payments, with appropriate recognition of valid year-to-year changes in input costs;

- reward improvements in the efficiency of the market;

- adequately adjust for differences in the illness burden of beneficiaries;

- recognize appropriate variations in local utilization patterns and practice style as they influence HMO health care practice;
- recognize appropriate and legitimate local variations in local input costs: and
- be relatively easy for the government to administer.

Comments on Proposed Changes to the Payment Methodology for Risk Contracts

Several bills have been introduced that would change the current risk contracting payment methodology. Our comments today are focussed on Senator Durenberger's Medicare Choice Act of 1994, and the Administration's Health Security Act.

S. 1996, Medicare Choice Act of 1994

We are pleased that Senator Durenberger has given improvement of the Medicare risk contracting program a high priority, and that he has introduced the Medicare Choice Act of 1994. The bill incorporates important principles of consumer choice among delivery systems for beneficiaries It also calls attention to the need for comparative information on health plan offerings that will permit Medicare beneficiaries to make truly informed choices. In addition, it acknowledges that the reimbursement mechanism must be improved in order for HMO options for Medicare beneficiaries to expand significantly in the future.

Important issues addressed by the bill include:

- consideration of a newly defined geographic areas for rate setting purposes. The current county basis on which the AAPCC rates are calculated is clearly unsatisfactory to all parties -- the seniors, the government, and the health plans -- and the Medicare market areas proposed in S. 1996 deserve further examination.
- introduction of a bid process into the rate-setting mechanism also has been considered by a GHAA Technical Panel, primarily composed of actuaries. The Panel found that a bid process holds promise for improving the reimbursement mechanism.

The bill also proposes that health plans must offer either the Medicare benefit package, including the Medicare cost-sharing levels, or "actuarially equivalent Medicare benefits," which would include all Medicare covered benefits with cost-sharing actuarially equivalent to the Medicare coinsurance and deductibles. This requirement would be difficult to calculate and would also have the effect of requiring HMOs to offer benefits less comprehensive than those necessary for the efficient delivery of high-quality care. Coverage of preventive services and a coordinated appfoach to care management that uses different settings of care, when appropriate, are critical to HMOs' basic benefit offerings.

We look forward to continuing to work with Senator Durenberger and his staff to ensure that a mechanism is developed that will allow Medicare beneficiaries to compare the value of the different options available.

Administration's Health Care Reform Proposal

While we find significant areas to support in the Administration's bill, such as comprehensive benefits and universal coverage, GHAA opposes the provisions that would add an arbitrary ceiling and floor to the AAPCC payment methodology, and it would drive HMOs away from Medicare rather than attracting us to it. There is wide recognition that the AAPCC payment mechanism is flawed, and any efforts to alter HMO risk-based Medicare reimbursement should address the underlying problems with the calculation rather than ignoring them.

The reduction that will result from application of the ceiling particularly inequitable since it is proposed in combination with a compounding reduction in the fee-for-service Medicare payments that create the AAPCC. In other words, this reduction would unfairly penalize risk contracting HMOs since they will already be impacted by Medicare cuts on the fee-for-service side. HMOs participating in Medicare risk contracts would thus be affected by fee-for-service reductions in several ways.

GHAA also opposes the proposal in the Administration's bill that would establish an outlier pool for high-cost cases, which would be funded by reducing the AAPCC. This is an expensive and unnecessary bureaucratic involvement in the risk process -- and it will also discourage HMO involvement in Medicare because it will be seen as a mechanism to cut Medicare costs. If the pool is not drawn upon by risk contractors with high-cost cases, then it will simply be an unfair way of reducing HMO payments.

The fact is that the outlier pool is not necessary -- commercial reinsurance is already available to HMOs who need it, and HMOs with sufficiently large enrollment self insure. It would be burdensome for HMOs to justify that they have high cost cases that qualify for the outliers, since HMOs that capitate providers may not have data readily available on costs for providing care to individual beneficiaries. It also would be burdensome for HCFA to audit the documentation produced by the risk contractors. The primary impact of the provision would be to increase administrative costs for the government and the HMOs, and to discourage HMOs from working with Medicare.

GHAA also is concerned about the coordinated open enrollment requirement. Medicare beneficiaries must be individually contacted and given a full explanation of the way in which HMO services are delivered by providers to ensure that beneficiaries are making an informed choice about HMO membership. Although comparative information about health plans is important, it is unlikely to be enough by itself to communicate the information needed by beneficiaries to make the right personal choice about joining an HMO.

Currently, many HMOs enroll Medicare beneficiaries on a year-round basis in order to permit adequate time for the contact necessary to fully inform prospective members and to accommodate the needs of employers for coverage of retirees. Additionally, enrollment of large numbers of Medicare beneficiaries at a single time of year could stress both administrative and delivery systems of HMOs. A more flexible approach to enrollment would be beneficial to both health plans and Medicare beneficiaries.

Conclusion: HMOs and Medicare Under Health Care Reform

Under health care reform, regardless of how the Medicare program is treated, there should be a strong commitment to offering Medicare beneficiaries a choice of delivery systems. HMO Medicare beneficiaries should continue to enjoy the same advantages of HMO membership as other HMO members -- high quality, affordable, comprehensive health care services.

GHAA and I look forward to working with the Committee. We are pleased that Senator Durenberger has focussed attention on the Medicare risk contracting program. We hope to be able to add our expertise to further refinements of the proposal.